CLIENT HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Person completing form:	
Address: **Telephone Numbers:** **E-mail:**	

HEALTH HISTORY

My child is immunized ☐ yes ☐ no		
Developmental History Please check if met within typical age range. List age acquired if later than typical development suggests.	Rolled Over	Babbled
	Sat alone	Said first words
	Crawled Walked	Began using 2-3 word phrases

List any medical problems that doctors have diagnosed and/or physical limitations:

Circle any that apply to your child:

Trach	Allergies ____________________	Hearing Aids	Wears glasses
G-Tube	Latex sensitivity	Hearing difficulties	Vision difficulties

Surgeries Yes/No

Year	Reason	Hospital

Current Physician:

Special equipment your child uses (e.g., splints, braces, adaptive utensils, assistive technology)

Therapy History

Previous/Current Speech Therapy Dates and Location	Previous/Current Occupational Therapy	Previous/Current Physical Therapy

Please turn to next page

Does your child attend a daycare, preschool, elementary, middle or high school?	
Name the School	Dates Attended
Does your child receive any accommodations at his/her school? YES NO	
If yes, please explain:	
Does your child have an ISP, IEP, IFSP, 504, etc? **YES NO**	
If yes, please bring copies to your first appointment.	

HEALTH AND DEVELOPMENT/BEHAVIOR

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS? (IF YOU CHECK AN AREA, PLEASE PROVIDE FURTHER EXPLANATION.			
☐ Eating Problems			
☐ Sleeping Problems			
☐ Motor Coordination Problems			
☐ Separation from parents			
☐ Attention Span			
☐ Aggression			
☐ Tantrums			
☐ Activity Level	☐ Overactive	☐ Lethargic	
☐ Bullying Behavior			
☐ Feeling Fearful/Anxious	☐Oppositional Behavior	☐Withdrawal/Depression	☐ Self-Injurious Behavior
☐ Impulsive Behaviors			
☐ Peer Relations			
☐ Relationships with Parent			
☐ Relationships with Siblings			

What are your child's strengths?
What are your child's areas of need?
What are your main concerns? Why are you coming to see us?