City Speech Center

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Client Profile
(Child)

Today's Date:___________________________ Who referred you? ________________

Child's Information

Name:__________________________________ Date of Birth: __________________________
Phone: _________________________________
Address: _______________________________
Siblings:____
(Names and Ages)

Mother's Information

Name: ___________________________ Home Phone: ____________________
Step mother? _______________________ Cell Phone: ______________________
Occupation:_________________________ Work Phone: _____________________
Address: ____
(if different from child's)
Email: ____________________________

Father's Information

Name: ___________________________ Home Phone: _____________________
Step father?_________________________ Cell Phone: ______________________
Occupation:_________________________ Work Phone: _____________________
Address:____
(if different from child's)

Educational Information

School Name: ____________________________ Phone:_________________________
Grade:_____________________________________ Teacher _______________________
Address:____
Previous Schools:____

Ever retained?____________________ Which year(s)?__________________
Receiving special services?__________ Which services?_________________
Contact person:____________________ Position:________________________
Ever tested outside school?_________ When?_________________________

By whom?_______________________ Position:_______________________
Where?____
(Please give name and phone number of the institution.)

Academic Strengths:____
Academic Difficulties:____
Other Difficulties:____
Did any other family member have the same difficulties?__________________
If so, who?____

HEALTH AND DEVELOPMENTAL INFORMATION

Pediatrician: ____________________ Phone:________________________
Address: ____
Please check any health concerns that you or your doctor have noticed about your child:

- ☐ Accident Prone
- ☐ Hyperactivity
- ☐ Over-tiredness
- ☐ Allergies
- ☐ Head Injuries
- ☐ Seizures
- ☐ Epilepsy
- ☐ Thumb Sucking
- ☐ Memory Trouble
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Stomach Aches
- ☐ Asthma
- ☐ Diabetes
- ☐ Vision Difficulties
- ☐ Bed Wetting
- ☐ Nightmares
- ☐ Sleep Disorders
- ☐ Heart Trouble
- ☐ Sinus Trouble
- ☐ Headaches
- ☐ Nail Biting
- ☐ Constipation
- ☐ Fevers
- ☐ Facial Tics
- ☐ Nose Bleeds
- ☐ Periods of Unconsciousness
- ☐ Blank Stares

Ear infections?___________________ At what ages?_______________________
How treated?____________________ Which ears? ________________________
(Antibiotics/Tubes in ears/Both)
Last Hearing Exam:______________ Results:____________________________
Does child use listening devices?_____ Type:_______________________________
Last Vision Exam:_________________ Results:____________________________
Does child wear corrective lenses?___ Type:_______________________________
Describe any serious injuries:____
Describe any hospitalizations:____
Is child on medication now?________ Reasons:___________________________
Child's medications:____

Problems during pregnancy:____
Problems during delivery:____
Medical problems in family:____
____

SPEECH AND LANGUAGE DEVELOPMENT

At what age did your child:

- Speak in single words? __________
- Put 2 or 3 words together?_____________
- Speak in sentences? _____________

Do you have difficulty understanding your child's speech?__________________________

Do others have difficulty understanding your child's speech?_________________________

Does your child have difficulty:

- Understanding directions? _______________ Understanding ideas or concepts?__________
- Understanding stories? __________________ Expressing stories?______________________
- Expressing directions? ___________________ Expressing ideas or concepts?______________

Languages spoken at home: ____

Languages spoken by your child: ____

Child's preferred language: ____

Other speech or language concerns: ____

MOTOR DEVELOPMENT

At what age did your child:

- Sit up? _________________
- Crawl? __________________
- Walk?___________________
- Self-feed?_________________
- Use toilet?________________

What is your child's hand preference for:

- Writing? ____________________________
- Eating?_______________________________

SOCIAL DEVELOPMENT

Does your child:

- ☐ Prefer to be alone instead of with others?
- ☐ Have difficulty getting along with others?
- ☐ Become frustrated easily?
- ☐ Cry often?
- ☐ Have a bad temper?
- ☐ Frequently become irritated or moody?
- ☐ Become upset by changes in routine?
- ☐ Demand much individual attention?
- ☐ Have difficulty accepting limits?
- ☐ Have difficulty accepting blame or criticism?
- ☐ Express himself or herself physically rather than verbally when upset?
- ☐ Have difficulty accepting responsibility and following through with it?