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New Client History

Child's Name

Date of Birth | Sex | Home Phone

Street Address | Apt. # | City | Zip Code

Mother's Name | Work Phone / Cell Phone

Father's Name | Work Phone / Cell Phone

Insurance Carrier / ID number _____

Please describe any pertinent birth history. _____

_____

_____

Please fill in the age at which your child sat alone _____, crawled ___

_____, walked _____, said his/her first word _____, became potty trained

Does your child attend school? _____ If yes, where? _____

Does your child receive therapy in school or privately? _____

If yes, in what areas and how frequently? _____

_____

Please describe any speech therapy history:

How did you hear about Simon Says? _____

What do you see as your child's strengths and needs? Please list 2 to 3 goals that you would like us to focus on during therapy. _____

_____

_____

Please describe any pertinent medical history and/or current medical conditions, including any diagnoses your child has received and any specific diagnostic codes you would like us to use for billing purposes. _____

_____

_____

Please list any current medications. _____

Please list any dietary needs/constraints. _____

_____

Please list any additional information you feel we should know about your child to best serve him/her _____

THUMB / FINGER SUCKING .....TONGUE THRUST INFORMATION

(answer only if these are areas of concern)

Describe your child's thumb/finger sucking habit _____

How long has your child been sucking his/her thumb/ fingers? _____

Do you see your child's tongue protrude from his/her mouth

At rest? _____

While eating? _____

While drinking? _____

When sleeping? _____

Is your child a "mouth breather"? _____

Has your child started any orthodontic treatment yet? If so, please describe..

_____

Please describe your main concerns with regards to your child's sucking habits or tongue thrust behaviors. _____

_____

Thank you for taking the time to answer these questions. Please bring them to your first appointment/ evaluation.