

# City Speech Centre

#375-2608 Granville St, Vancouver, BC, V6H 3V3

Telephone: 604-716-5241

## 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:

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

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: \_\_\_\_\_

\_\_\_\_\_

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?