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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?