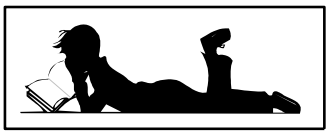

KINGSGATE SPEECH, LANGUAGE & READING

CLIENT INFORMATION SHEET

Child's Name _____ Date_____

DOB_____ Age_____ Grade _____ School _____

Parent's Name _____ Work # _____

Address:_____ Home # _____

_____ E-mail _____

Parent's Name _____ Work # _____

Address:_____ Home # _____

_____ E-mail _____

Names and Ages of Siblings: _____

Please list principle concern for seeking this evaluation/treatment: _____

_____

Referred by:_____

Medical Conditions/Diagnosis: _____

_____

Diagnosis made by: _____

Is your child currently taking any medications? If so, please describe: _____

_____

Medical/Developmental History

Describe any problems during pregnancy, labor or delivery: _____

_____

_____

Describe any visual or hearing difficulties:_____

_____

Is there a history of ear infections? If so, please describe: _____

_____

General impression of your child's motor development:_____

_____

Kathleen Boroughs, MS, CCC
Speech-Language Pathologist
kingsgatespeech@aol.com

17220 127th Pl. NE, Suite 302
Woodinville, WA 98072
(206) 446-1839

General impression of your child's speech and language development: _____

_____

_____

Any other pertinent medical/health conditions:_____

_____

_____

Has either parent or any other family members (siblings, relatives) had any difficulty learning to read? _____

_____

_____

Is there any other history of learning problems in your family? _____

_____

_____

School History

Year/Grade	School Name	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What concerns have been expressed by your child's teachers, principal, or school specialists?

_____

_____

_____

Has your child received any prior formal testing (speech-language pathologist, psychologist, occupational therapist, physical therapist, learning specialist, etc.) _____

_____

_____

_____

Does your child currently have an IEP? _____

List any additional treatments/tutoring your child is receiving at this time: _____

_____

_____

What is your child's attitude towards school? _____

_____

_____

Please list what you believe to be your child's areas of strength: _____

_____

_____

Please list what you believe to be your child's areas of weakness: _____

_____

_____

Please indicate any areas of difficulty that your child has had in the past or continues to have presently:

- ☐ Difficulty learning the alphabet
- ☐ Difficulty associating letters with sounds
- ☐ Difficulty rhyming
- ☐ Difficulty with memory for words/names
- ☐ Difficulty with handwriting
- ☐ Difficulty with spelling
- ☐ Word-finding difficulties
- ☐ Difficulty following directions
- ☐ Problems with time concepts (before, after, yesterday, tomorrow)
- ☐ Difficulty learning the days of the week or the months of the year
- ☐ Difficulty expressing himself clearly (either when retelling an experience or explaining an event)
- ☐ Problems with listening comprehension
- ☐ Problems with reading comprehension
- ☐ Speech/articulation problems
- ☐ Late talking compared to other children
- ☐ Difficulty with attention or concentration
- ☐ Difficulty distinguishing 'left' from 'right'
- ☐ Difficulty with math calculations
- ☐ Difficulty with math word problems
- ☐ Difficulty using correct grammar (She catched the ball)
- ☐ Mixing up sounds or syllables in words ("aminal" for "animal")
- ☐ Poor study habits or difficulty completing homework

Please provide any additional information that you feel may be relevant to your child's speech, language, reading or learning difficulty. Your comments and observations are VERY important.

_____

_____

_____

_____

Your child's interests/activities/hobbies/sports _____

_____

What motivates/discourages your child's behavior as it pertains to learning? What behavioral approaches work/don't work?_____

_____

_____

In what ways do you hope your child can be helped? _____

_____