Language & Learning Arts PLLC
Speech-Language Pathology Services

371 NE Gilman Blvd, Suite 320
Issaquah, WA 98027

Phone: (425) 427-1075
Fax: (425) 657-0691
E-mail: info@llaslp.com

Client History

Client Name: _____ Date of birth: _____

Pre-Natal & Birth History

Did the mother smoke cigarettes during pregnancy? Yes No

Was there any use of illegal drugs during pregnancy? Yes No If yes, type: _____

Was there any use of prescription drugs during pregnancy? Yes No If yes, type: _____

Was there any use of alcohol during pregnancy? Yes No

Was your child born prematurely? Yes No If yes, gestational age: _____

Were there any complications during delivery? Yes No If yes, describe: _____

_____

Developmental History

At what age was your child: Taking first steps? _____

Using first words? _____

Toilet trained during the day? _____ During the night? _____

Did your child have any difficulties breast or bottle feeding? Yes No If yes, describe: _____

_____

Is your child a picky eater? Yes No Describe difficulties with food: _____

_____

Does your child have a history of ear infections? Yes No If yes, age and frequency: _____

General Health

Please list any major illnesses, accidents, or health conditions:

Illness/accident/condition	Age

Please list any allergies, including food allergies:

Allergy	Reaction

Please list any medication and the dosage/frequency :

Medication	Condition	Dosage

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Academic History

Current school: _____ Grade: _____

Other schools attended: _____

_____

Does your child enjoy school? Yes No

Is your child experiencing any academic issues? Yes No If yes, describe: _____

_____

_____

Previous evaluations: Date: _____ Evaluator: _____

Date: _____ Evaluator: _____

Date: _____ Evaluator: _____

Does your child have an I.E.P. or accommodation plan? Yes No (if yes please provide a copy)

Does your child have friends at school? Yes No Does your child have a best friend? Yes No

Does your child wear glasses? Yes No If yes, distance, near, or both? _____

Family Information

Is your child adopted? Yes No If yes, at what age? _____

Does your child have any siblings? Yes No If yes please list siblings names and ages:

Sibling name	Age

Significant family history, including learning disabilities, language delays, dyslexia, ADD, depression, anxiety, etc.

Disorder	Relative

What languages are spoken in your home? _____ Primary Secondary

_____ Primary Secondary

Initial Consultation:

Who referred you for an evaluation/therapy? _____

What concerns do you have regarding your child's speech, language and learning? _____

_____

_____

Thank you taking the time to complete this questionnaire.
Please let us know if you have any additional questions or concerns that were not covered!