Core4 Therapy Group
Speech-Language Pathology Services
120 Kentucky Avenue, Suite 110
Lexington, Kentucky 40502
859 225-5424

Client Information and Medical History

Client Name: _____ Date of Birth:_____

Parent/Guardian: _____
Address:_____
Home Phone: _____ Cell Phone: _____ Work Phone_____
Email:_____
Siblings: _____ Age: _____
_____ Age: _____
_____ Age: _____
Name of the Daycare, Preschool or School your child attends: _____
_____ Grade_____
Extra Curricular Activities and Interests: _____
_____

Pregnancy: Normal _____ Difficult _____ Explain if Difficult_____
Delivery: Normal _____ Difficult _____ Explain if Difficult_____
Condition of child at birth: _____
Who is your child's pediatrician? _____ Phone: _____
List illnesses, surgeries and injuries your child has experienced: _____
_____
Does your child have allergies? If so what kind? _____
Does your child have a history of ear infections? _____
Does your child have ear tubes? _____ Doctor _____ Date
_____ Has he/she had more than one set?_____
Has your child had surgery or any serious illnesses? _____ if so, please explain: _____
_____
Is your child taking any medications? If so please list them: _____
_____
Does your child have any sleeping difficulties?: _____
If so, please describe the sleeping difficulties: _____

Approximate age that your child: Sat _____ Crawled _____ Walked _____
Babbled _____ Said first words _____ Produced simple phrases and sentences _____

Was your child referred by a Doctor _____Teacher _____ Other _____

What is your concern about your child's communication skills and/or learning abilities?_____
_____
_____

Does your child have a diagnosed speech/language disorder or any other disorder?_____

What is the diagnosed delay or disorder? _____
_____
Do you have any other concerns about your child?_____
_____
Has your child received previous speech/language therapy or other services? _____
If so, where did you child receive services? _____
_____
Dates of services: _____
Do any other family members have a history of a speech/language disorder?_____
If so, please describe: _____
_____
Do you have Evaluation Reports, Therapy Reports , Progress Reports, etc. from previous services?
_____
Can you provide copies of these?_____
What other service has your child received? OT_____, PT_____, DI_____, Special Education Instruction_____, Counseling _____, Other _____
From whom?_____
_____

Best days of the week and times for therapy: M____ T ____ W ____ TH ____ F ____
Morning _____ Afternoon_____ Evening _____
Preferred therapy site: Daycare ____ Preschool ____ School ____ Core4 Office____ Home ____

Emergency Contacts: 1. _____ Phone: _____
2. _____ Phone: _____

_____ _____
Parent/Guardian Signature Date