Educational Therapist
Rosaura Raya-Markham, M. Ed.

CLIENT INFORMATION FORM

THIS INFORMATION IS CONFIDENTIAL

To New Clients:

Please answer each question as fully as possible. The information requested is strictly confidential, and is used only for the purpose of designing an appropriate educational program to meet new clients' individual needs. If you have any questions regarding this questionnaire, please let me know. Thank you for your assistance.

DATE: _____ **REFERRAL SOURCE**: _____

1. BACKGROUND

NAME OF CLIENT _____ NICKNAME _____
Last First Middle

ADDRESS _____

_____

PHONE _____

AGE _____ **BIRTHDATE** _____ **SCHOOL GRADE** _____
Yrs. mo. Mo. day year

Is Client adopted? _____ At what age? _____

Client's principal residence is with: Mother and Father _____;

Mother _____; Father _____; Other (Specify) _____

FAMILY INFORMATION

	MOTHER	**FATHER**
NAME		
ADDRESS		
PHONE: CELL PHONE: HOME	( ) ( )	( ) ( )
BIRTHDATE		
OCCUPATION		
EMPLOYER		
EDUCATION (HIGHEST LEVEL COMPLETED)		

PARENTS' MARITAL STATUS: Married ____ Divorced ____ Widowed ____ Remarried ____

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If remarried, which parent? _____

LIST BROTHERS AND SISTERS IN ORDER OF BIRTH

NAME	AGE	SCHOOL GRADE	RELATIONSHIP TO CLIENT

Other members of this household? _____

Please list any agencies, psychologists, speech pathologists, tutors, or educational therapists who have evaluated and/or provided treatment for this client.

NAME **PROFESSION** **DATES OF TREATMENT**

_____

_____

_____

_____

2. SCHOOL HISTORY

LIST ALL SCHOOLS ATTENDED:

Preschool _____

Elementary _____

_____

Middle School _____

High School _____

School currently attended _____

Address _____

Teacher name _____

Has this client ever repeated a grade? _____ If so, explain _____

Has this client received special services in school, such as resource or special day classes? Please list:

_____

_____

Age at which you started to suspect learning problems _____

Age at which school related problems were identified _____

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Has the school indicated that client is below grade level in reading or other academic subjects? If yes, give estimated grade level _____

What is the client's general feeling about school? Does s/he see herself/himself as a problem learner?

_____

_____

3. SPEECH AND LANGUAGE INFORMATION

Primary language spoken at home _____

Other languages spoken? _____

If English is not the primary language, when did client learn English? _____

As a child, what adults did client have to talk with, especially adults who had time to listen and have a conversation with client? List adults, and relationship to client. _____

_____

Did any of the available adults have a speech impairment? Please describe any possible effects on client.

_____

During the first six months of life, did the client babble and coo? _____

As a child, did client ask for names of things? _____

Does client now forget or have problems saying the exact name of common objects? _____

As a child, did client ask for the meanings of unknown words? _____

At what age was client's speech clear and easy for non-family members to understand? _____

If client has problems with clarity of speech, please explain _____

How many times a week did you or other adults read to client (when a child) _____

Did (or does) client request adults to read aloud:

Regularly _____ Infrequently _____ Never _____

Does client pick up books and read voluntarily:

Regularly _____ Infrequently _____ Never _____

At what age as a child did client ask to write his/her name and other words? _____

Does client speak more than, less than, or about as much as siblings? _____

How well does client express strong feelings in words? _____

4. MEDICAL HISTORY

A. PRENATAL/NEONATAL HISTORY

If client was adopted, at what age did child enter your home? _____

Was child ever in foster care? If so, indicate length of stay and age at leaving _____

B. PREGNANCY HISTORY

Length of pregnancy (40 weeks = full term) _____

Medications used _____

Serious illness/accidents during pregnancy _____

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Use of narcotic drugs? _____ Alcohol? _____ Smoking? _____

Pregnancy was: Easy _____ Average _____ Difficult _____

C. BIRTH

Duration of labor _____ Birth weight _____

Type of delivery _____ Birth injuries? _____

Seizures? _____ Infections? _____

Breathing difficulties? _____ Feeding difficulties? _____

Jaundice or anoxia? _____ Other? _____

D. CHILDHOOD

During the first months of life, was this child:

Extremely active and strong? _____ Normally active? _____ Sluggish and weak? _____

During the first months of life, was this child:

Highly attentive to sights and sounds? _____

Moderately attentive to sights and sounds? _____

Unresponsive to sights and sounds? _____

Please check any of the following conditions your child had, and age at which it occurred:

_____ Multiple ear infections (before age 5) _____

_____ Meningitis/Encephalitis _____

_____ Serious infection (specify) _____

_____ Head injury (with concussion, loss of consciousness) _____

_____ Chronic headaches or migraines _____

_____ Seizures _____

_____ Allergies (list type and treatment) _____

_____

List childhood illnesses/hospitalizations. Give age, type, and severity/complications.

_____

_____

_____

Date of last hearing check? _____ Checked by? _____

Date of last vision check? _____ Checked by? _____

Wears glasses? _____ Specify when glasses are required _____

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Was client ever on medication for more than a month, for any illnesses or problems, including ear infections or seizures? (Specify) _____

Current medications? _____

Supervised by? _____

Has client had any of the following? If so, check and state results, if known:

_____ Electroencephalogram (EEG) _____

_____ Computerized Tomography (CT scan) _____

_____ Head X-rays _____

_____ Blood chemistries _____

5. DEVELOPMENTAL HISTORY

Was this an easy or difficult baby to care for? _____

Did development overall seem slow, average, or advanced? _____

Check any areas of concern:

_____ Gross motor (Large body skills, running, balancing, etc.)

_____ Fine motor (Hand and manipulative skills, drawing, cutting, etc.)

_____ Social skills (Making and keeping friends, sharing, etc.)

_____ Adaptive skills (Feeding, dressing, bathroom skills, etc.)

_____ Language (Speaking, understanding instructions, clarity of speech, etc.)

Milestones: State age when these skills emerged

_____ Turned over; _____ Sat alone; _____ Walked alone; _____ Crawled; _____ Fed self;

_____ First words; _____ Toilet trained; _____ Slept through night;

_____ Preferred use of one hand (which?); _____ Full sentences

Did (or does) client experience:

_____ Feeding problems; _____ Sleep problems; _____ Colic; _____ Rocking/head banging;

_____ Breath holding; _____ Severe temper tantrums; _____ Stuttering; _____ Constipation;

_____ Tics or nervous twitches; _____ Stomach aches

Can client:

_____ Ride a bicycle; _____ Jump rope; _____ Skate; _____ Skip; _____ Swim;

_____ Throw and catch a ball

Hobbies: _____

_____

What activities is client encouraged to pursue:

_____ musical; _____ religious; _____ academic; _____ sports; _____ artistic; _____ mechanical;

_____ other: _____

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In what activities has client been particularly successful and/or interested?

_____

_____

_____

OUT-OF-SCHOOL ACTIVITIES:

EXPERIENCES	VERY OFTEN	OCCASIONALLY	INFREQUENTLY
Music lessons			
Religious training			
Family hobbies			
Day camp			
EXPERIENCES, continued	**VERY OFTEN**	**OCCASIONALLY**	**INFREQUENTLY**
Resident camp			
Vacation travel			
Camping			
Museums			
Neighborhood play			
Organized sports			
Swim or dance class			
Reading (independently)			
Theater, Movies			
Computer or other electronic games			
Computer based activities (Internet, etc.)			
TV (note hours per day)			

6. BEHAVIOR

Cross out those behaviors that do not apply to client. Check the box that indicates how frequently the behavior occurs.

BEHAVIOR	USUALLY	OFTEN	SELDOM	NEVER
Cheerful				
Confident				

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Fidgety, restless				
Argumentative				
Shy, withdrawn				
Easily frustrated				
Very active physically				
Very talkative				
Bed wets				
Awkward, clumsy				
Difficulty in concentration				
Defiant				
Leaves projects uncompleted				
Sleeps poorly				
Eats little				
Short attention span				
Forgets easily				
Loses possessions				
BEHAVIOR, continued	**USUALLY**	**OFTEN**	**SELDOM**	**NEVER**
Resents or forgets chores				
Resents or forgets homework				
Plays well with others				
Expresses self well verbally				
Fearful				
Poor sense of time/direction				
Generally optimistic about self				

Please comment on any significant academic, physical, or social difficulties that client has experienced:

_____

_____

_____

_____

7. GUIDANCE ISSUES

Client is: _____ easily managed; _____ fairly easily managed' _____ difficult to manage

Client is sensitive to approval and disapproval: _____ extremely; _____ average; _____ rarely

Methods of guidance used in family:

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By mother _____

By father _____

Are there differences of opinion in your family or household about behavior management of client?

_____

For what behaviors do you have to discipline? _____

Client's reaction to methods of discipline? _____

Which methods work best? _____

Do any of those who supervise this client have more difficulty/ success than others? Describe fully:

_____

_____

What present behavior is most difficult for you to cope with? _____

What present behavior do you hope to change? _____

What do you value most about this client? _____

_____

_____

_____

_____

What words would this client use to describe himself/herself? _____

_____

_____

_____

_____

8. FAMILY MEDICAL HISTORY

List family members and relatives with:

CONDITION	RELATION TO CLIENT
Reading problems (dyslexia)	
Speech problems or late speaking	
Hearing problems	
Learning difficulties	
Math problems	
Writing problems	
Hyperactivity	

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Have any of the above problems had any effect on client? Specify: _____

Do any of the following medical or genetic conditions run in the family?

_____ Migraine

_____ Seizures or convulsions

_____ Neurological disorders

_____ Depression

_____ Other psychiatric conditions (specify) _____

Please add any comments here that would help us further understand this client:

_____

_____

_____

_____

_____

_____

_____

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