Jodie K. Schuller & Associates
Therapies For Success

CLIENT PROFILE

(Adult)

Date _____ Referred by _____

Name _____ Birthdate _____ Age _____

Address _____
(Street) (City) (State) (Zip)

Telephone: Cell _____ Home _____

Email: _____

Occupation _____ Employer _____

Spouse's Name _____

Spouse's Occupation _____ Spouse's Work Phone _____

IS YOUR INSURANCE MEDI-CAL/MEDI-CARE? YES ☐ NO ☐

Insurance Carrier _____ Phone _____

Subscriber # _____ Group # _____

Insurance Address: _____

EDUCATIONAL HISTORY AND INFORMATION

Highest Level of Education

	SCHOOLS ATTENDED	YEARS ATTENDED	YEAR GRADUATED
Grammar School	_____	_____	_____
Jr. High School	_____	_____	_____
Sr. High School	_____	_____	_____
College(s)	_____	_____	_____
Trade School(s)	_____	_____	_____
Other	_____	_____	_____

Describe your strengths

Describe your areas of difficulty

Were you enrolled in special education as a child? _____

If so, which program(s)? _____

MEDICAL HISTORY AND INFORMATION

Physician's Name _____ Specialty _____ Phone _____

Physician's Address _____

Describe any serious illnesses or injuries _____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Are you chronically taking any medication? _____ What? _____

For what reason? _____

Please check any health concerns that you or your doctor have noticed:

☐ Accident Prone	☐ Diarrhea	☐ Hyperactivity	☐ Over-Tiredness
☐ Allergies	☐ Epilepsy	☐ Indigestion/Stomachaches	☐ Pencil/object Sucking
☐ Asthma	☐ Facial Tics	☐ Lack of Consciousness	☐ Seizures
☐ Fevers	☐ Memory Lapses	☐ Frequent Urination	☐ Sinus Trouble
☐ Blank Stares	☐ Headaches	☐ Nail Biting/Sucking	☐ Sleep Disorders
☐ Constipation	☐ Head Injuries	☐ Nightmares	☐ Vomiting
☐ Diabetes	☐ Heart Trouble	☐ Nose Bleeds	☐ Open-mouth Breathing

Explain items checked above

Describe other health problems

Date of last vision screening _____ Results _____

Date of last hearing screening _____ Results _____

SPEECH AND LANGUAGE INFORMATION

Do you:	No	Yes	Explain
Have difficulty "sounding out" words (phonetics)?	○	○	_____
Have difficulty with spelling?	○	○	_____
Have difficulty comprehending what you read?	○	○	_____
What do you read?	○	○	_____
Have difficulty pronouncing certain sounds?	○	○	_____
If yes, which sounds?	○	○	_____
Have difficulty pronouncing certain words?	○	○	_____
If yes, which words?	○	○	_____
Do you have difficulty retrieving words when you speak?	○	○	_____
Explaining concepts or ideas ?	○	○	_____
Telling stories	○	○	_____
Do others have difficulty understanding you?	○	○	_____

If yes, why? _____

Describe other speech, language or educational concerns

What do you hope to gain by coming to Jodie K. Schuller and Associates?

SLEEP PATTERNS

How many hours of sleep do you get nightly?_____ In what environment?_____

Is snoring present?_____ teeth grinding?_____ leg jerks?_____

How often do you wake-up at night?_____ get out of bed?_____

Do you feel/look exhausted after a night of sleep?_____

Do you nap/fall asleep during the day?_____ How often?_____ For how long?_____

ADDITIONAL COMMENTS/CONCERNS

Please bring this Questionnaire/Intake Packet with you for your appointment.