Jodie K. Schuller & Associates
Therapies For Success

CLIENT PROFILE

(Child)

Date _____ Referred by _____

Child's Name _____ Birthdate _____ Age _____

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

Home Telephone: _____Cell Phone: _____

Email: _____

Mother's Name _____
(please indicate if step-relationship)

Father's Name _____
(please indicate if step-relationship)

Address and phone (if different than child's): _____

_____

Mother's Occupation _____ Employer: _____ Work Phone _____

Father's Occupation _____ Employer: _____ Work Phone _____

Names and ages of Brothers/Sisters (please indicate if step-relationship)

_____/ Age ___ _____ /Age ___ _____ / Age ____

IS YOUR INSURANCE MEDI-CAL/MEDI-CARE? Yes ☐ No ☐

Insurance Carrier _____ Phone _____

Member's Name: _____

ID # _____ Group # _____

Insurance Address: _____

Previous diagnoses & codes (for better insurance reimbursement): _____

EDUCATIONAL HISTORY AND INFORMATION

Name of School _____ Teacher _____

Teacher email: _____

Previous Schools Attended _____ Years _____

Present Grade Level _____ Ever Retained? _____ Year _____

Does child have an IEP? _____ For which program? _____

Contact Person _____ Position: _____

Has outside testing ever been done? _____ When? _____

Where? _____ By Whom? _____

Previous diagnoses & codes (for better insurance reimbursement): _____

Child's school/academic strengths _____

_____

Other strengths _____

_____

School/academic areas of difficulty _____

_____

Other areas of difficulty? _____

Grades in Reading?_____Spelling?_____Oral Expression?_____Written Expression?_____

Social Skills?_____Math?_____Other?_____

Did any other family members have difficulties similar to child's? _____

If so, who? _____

HEALTH AND DEVELOPMENTAL HISTORY

During Pregnancy:

- ☐ Smoking
- ☐ Bleeding
- ☐ Injuries Requiring Hospitalization
- ☐ Threatened miscarriage
- ☐ Radiation
- ☐ Medication
- ☐ Alcohol/Drug Use
- ☐ High Blood Pressure
- ☐ Infection
- ☐ Gestational Diabetes

Explain items checked above

At Birth:

Delivered via: ☐ normal childbirth ☐ planned C-section ☐ emergency C-section ☐ induced labor

- ☐ Born prematurely; weeks gestation_____
- ☐ Jaundice
- ☐ Cord wrapped around neck
- ☐ Cardiac problems
- ☐ Oxygen required
- ☐ Intubation
- ☐ Difficulty with alertness
- ☐ Difficulty sucking/swallowing/latching
- ☐ Tube feeding
- ☐ Difficulty breathing

Explain items checked above

Feeding/Oral motor milestones:

☐ Breastfeeding; until what age?_____

☐ Bottle feeding; until what age?_____

☐ Sippy cup drinking; until what age?_____

☐ Straw drinking; at what age?_____

☐ Cup drinking; at what age?_____

☐ Eating solid foods; at what age?_____

☐ Feeding self; at what age?_____

Is your child a picky eater? ☐ Yes ☐ No

List some favorite foods:_____

List any foods commonly refused/avoided_____

Is there a history of drooling?_____

Did your child have problems with latching? _____

Does/did your child use a pacifier?_____; Until what age?_____

Does/did your child suck a finger/thumb?_____; Until what age?_____

Does/did your child suck a blanket/article of clothing?_____; Until what age? _____

Does/did your child have a tongue thrust?_____; Until what age?_____

Is there a family history of feeding problems?_____

Explain items checked above_____

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
☐ Bedwetting	☐ Fevers	☐ Memory	☐ 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

Has child had chronic ear infections? _____

How were they treated? Antibiotics ☐ PE Tubes ☐ Both ☐

At what age(s) were P.E. tubes inserted? _____

Pediatrician's Name _____ Phone _____

Pediatrician's Address

_____

Previous diagnoses & codes: _____

Is child chronically using any medication? _____ What? _____

For what purpose? _____

Have there been any significant injuries or hospitalizations? _____ At what age(s)? _____

Describe _____

Date Last Vision Exam _____Does child wear corrective lenses?_____

For what condition?_____

Date Last Hearing Exam _____ Results? _____

Are there any significant medical problems in your family? _____ Describe _____

_____

SLEEP PATTERNS

How many hours of sleep does your child get nightly?_____ In what environment?_____

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

How often does your child wake-up at night?_____ get out of bed?_____

Does your child wet the bed?_____ How often?_____

Does your child complain/look exhausted after a night of sleep?_____

Does your child nap/fall asleep during the day?_____ How often?_____ For how long?_____

MOTOR DEVELOPMENT

When did child begin sitting?_____crawling? _____walking?_____

Which hand does child use to write? _____ to eat? _____

Describe other motor concerns_____

SOCIAL DEVELOPMENT

Does your child:	No	Yes	Explain
Prefer to be alone instead with others?	◯	◯	
Have difficulty getting along with others?	◯	◯	
Become easily frustrated?	◯	◯	
Cry often?	◯	◯	
Have a bad temper?	◯	◯	
Become frequently irritated or moody?	◯	◯	
Become upset by changes in routine?	◯	◯	
Demand much individual attention?	◯	◯	
Have difficulty accepting responsibility and limits?	◯	◯	
Have difficulty accepting blame or criticism?	◯	◯	
Express himself/herself physically rather than verbally when emotionally upset?	◯	◯	
Have difficulty accepting and following through with responsibilities?	◯	◯	
Have difficulty starting/maintaining conversations about others?	◯	◯	
Have difficulty making/keeping friends?	◯	◯	

SPEECH AND LANGUAGE INFORMATION

When did child begin speaking in single words? _____

With 2 or 3 words together? _____ In sentences? _____

Can you understand child's speech? _____ Can others? _____

Does child have difficulty understanding directions? _____

Ideas and concepts? _____ Stories? _____

Does child have difficulty expressing directions? _____

Ideas and concepts? _____ Stories? _____

Does child speak a second language? _____ What? _____

What is the child's preferred language? _____

Describe other speech/language concerns

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