J5 Therapy, Inc.
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Client History Form

Child's Name:		☐ Male ☐ Female	
Child Care Center:		**Arrival Time:**	**Leave Time:**
Date of Birth:	**Medicaid #:**		**Part A** ☐ **or B** ☐
Insurance Company & Policy #:			
Primary Care Physician & Clinic Name:			
Parents Name:			
Address:			
Phone:			
Email:			
Date of his/her well child checkup:			
Siblings (names and ages):			

Medical Diagnosis:

Does your child have any allergies? (If yes, List)	**Yes:** ☐	**No:** ☐
Does your child take medication? (If yes, List)	**Yes:** ☐	**No:** ☐
Has your child ever been hospitalized or suffered any serious injuries?	**Yes:** ☐	**No:** ☐
If yes, at what age and how many?		
Has your child ever had an ear infection?	**Yes:** ☐	**No:** ☐
If yes, at what age and how many?		
Has the child hearing ever been tested?	**Yes:** ☐	**No:** ☐
When: **Results:**		

Is there a family history of developmental delays, learning, hearing or speech impediments?

Length of Pregnancy:		**Complications**	**Yes:** ☐ **No:** ☐
If yes, please explain:			
Birth Weight:	**Length of Hospital Stay:**		

At what age did your child:

Crawl:	**Walk:**	**Babble:**	**Sit up Alone:**	**Say 1st word:**

Please list any concerns you have about your child's speech & language below: