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Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Diagnosis (if applicable/known): _____

Parent(s) / Guardians: _____

Address: _____

City, State, Zip: _____

Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email #1:_____ Email #2: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

How did you hear about [Private Practice / Private Practitioner Name]?

_____

Family Background

Parent 1 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Parent 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 3 Name: _____ Age: __ Sex: __ Speech Issues:_____

Language(s) that are spoken in the home: _____

Evaluation

Briefly describe your concerns regarding your child's communication skills:

_____

_____

_____

What are you expecting out of this evaluation / meeting? _____

_____

_____

Has the child had a previous speech, language or feeding evaluation / treatment? ☐ Yes ☐ No

By whom: _____When: _____

Describe the results:

_____

_____

_____

At what age did you first notice the problem? _____

Does any other family member of a speech/language disorder or communication difficulties? If yes, please describe.

_____

_____

_____

Is the child aware of or frustrated by their communication difficulties?

_____

_____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

_____

_____

_____

_____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐ Yes ☐ No

Describe: _____

2. Was there any stress during the pregnancy? ☐ Yes ☐ No

Describe: _____

3. Were there any complications during labor or delivery? ☐ Yes ☐ No

Describe: _____

Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)

2. The child was _____ lbs ____oz and _____ inches at birth

3. Please describe any complications or concerns during labor or delivery:

_____

_____

_____

Check and describe all that apply:

☐ Adenoidectomy Describe: _____

☐ Asthma Describe: _____

☐ Behavior Issues Describe: _____

☐ Brain injury Describe: _____

☐ Breathing problems Describe: _____

☐ Cardiac issues Describe: _____

☐ Chicken pox Describe: _____

☐ Diabetes Describe: _____

☐ Ear infections Describe: _____

☐ Ear tubes Describe: _____

☐ Encephalitis Describe: _____

☐ Frequent colds Describe: _____

☐ High fever Describe: _____

☐ Measles Describe: _____

☐ Meningitis Describe: _____

☐ Mumps Describe: _____

☐ Seizures Describe: _____

☐ Sensory issues Describe: _____

☐ Tongue tie Describe: _____

☐ Tonsillitis Describe: _____

☐ Tonsillectomy Describe: _____

☐ Traumatic brain injury Describe: _____

Is the child up to date with immunizations: ☐ Yes ☐ No

Has the child ever had surgery? ☐ Yes ☐ No

Please describe: _____

_____

Has the child ever been hospitalized: ☐ Yes ☐ No

Please describe: _____

Has the child ever been in a serious accident? ☐ Yes ☐ No

Please describe: _____

_____

Does the child have a chronic illness? If so, please describe: _____

_____

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe: _____

Does the child have a history of ear infections, tubes, etc. or use hearing aides? ☐ Yes ☐ No

Describe: _____

Does the child have any known hearing loss? ☐ Yes ☐ No

Describe: _____

_____

If you have any concerns about the child's hearing, please describe: _____

_____

Describe the child's current health status: _____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐ Developmental Pediatrician _____

☐ Neurologist _____

☐ PT _____

☐ OT_____

☐ SLP_____

☐ Behavioral Therapist _____

☐ Educational Consultant _____

☐ Psychologist / Psychologist _____

☐ Other: _____

Developmental History

At what age did the child do the following:

Sit alone: _____ Crawl: _____

Stood Up: _____ Walk: _____ Made

Sounds: _____ First Word: _____

Combined Words: _____ Sentences: _____

Fed Self: _____ Understood by Others_____

Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:

☐ Choke on liquids ☐ Choke on foods

☐ Avoid foods ☐ Maintain a special diet

☐ Use a pacifier / suck thumb ☐ Mouth objects

Please describe any of the above: _____

_____

Communication

If under 4 years of age, how many words does the child say:

☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-150 ☐ 151-300 ☐ 301-500 ☐ 501+

Does the child produce sentences of the following length:

☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____

_____

_____

Does the child have any difficulty with the following:

☐Attention ☐Frustration Tolerance

☐ Aggression ☐ Anger

☐ Answering simple questions ☐ Answering –wh questions

☐ Understanding people ☐ Following directions

☐ Excessive drooling ☐ Chewing or eating

☐ Producing speech sounds ☐ Stuttering

☐ Reading ☐ School work

☐ Remembering ☐ Maintaining eye contact

☐ Transitions ☐ Word Retrieval

☐Other difficulties: _____

Please describe any of the above: _____

_____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe:

_____

_____

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What is the name of the program? _____

What is their grade level: _____

Please describe any educational difficulties or learning challenges that this child has faced:

_____

_____

Social History

Describe how the child interacts with parents, siblings, or other family members:

_____

_____

Please describe the communication difficulties the child faces in the home environment:

_____

_____

What are the child's favorite activities?

_____

_____

Describe how the child interacts with other children: _____

_____

What are your goals for the child over the next 6 months?

_____

_____

Is there anything else that is important for us to know about the child?

_____

_____

Person filling out the form: _____

Relationship to the child: _____

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