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| **CHILD INTAKE FORM** |

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| To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).  * Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services). * PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST AT YOUR CHILD’S FIRST THERAPY SESSION. |

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| CHILD’S INFORMATION | | | | | | | |
| FULL NAME | | | | GENDER 🞎 Male 🞎 Female | | | DOB |
| CURRENT AGE | | NAME OF SCHOOL | | | | | GRADE |
| PRIMARY CARE PHYSICIAN (PCP) | | | | | PCP PHONE | | |
| DESCRIBE YOURMAIN CONCERNS Include when the problem was first noticed, who noticed it, and where the problem occurs. |  | | | | | | |
| How does your child react tobeing misunderstood orunable to communicate? | 🞎 Tries again/revises 🞎 Becomes angry/frustrated 🞎Other:  🞎 Gives up 🞎 Doesn’t notice | | | | | | |
| Why are you seeking speech-language services for your child? |  | | | | | | |
| Has your child’s physician noticed these concerns?If yes, what were his/her recommendations? |  | | | | | | |
| How did you learn about us? |  | | | | | | |
| In the table to the right,list all other servicesyour child has received,including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below.🞎 None | TYPE OF SERVICE | | DATES/AGE | | | NAME OF PROVIDER | |
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| FAMILY’S INFORMATION | | | | | | |
| With whom does your child live? (Check all that apply) | 🞎 Biological parent(s) 🞎 Adoptive parent(s) 🞎 Legal guardian(s)  🞎 Grandparent(s) 🞎 Sibling(s) 🞎 Other: | | | | | |
| In the table to the right,list all family memberswho live in the same homeas your child. | NAME | | AGE | RELATION TO CHILD | | |
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| Do you have any family pets?(List name and type) |  | | | | | |
| **PARENT 1 INFORMATION** | | | | | | |
| FULL NAME | | GENDER 🞎 Male 🞎 Female | | | | DOB |
| ADDRESS | | CITY | | | | ZIP |
| PHONE 1 🞎 CELL 🞎 HOME 🞎 WORK | | EMAIL | | | | |
| PHONE 2 🞎 CELL 🞎 HOME 🞎 WORK | | PREFERRED METHOD OF CONTACT | | | 🞎 PHONE 1 🞎 EMAIL  🞎 PHONE 2 | |
| PLACE OF EMPLOYMENT | | POSITION | | | | |
| **PARENT 2 INFORMATION** | | | | | | |
| FULL NAME | | GENDER 🞎 Male 🞎 Female | | | | DOB |
| ADDRESS | | CITY | | | | ZIP |
| PHONE 1 🞎 CELL 🞎 HOME 🞎 WORK | | EMAIL | | | | |
| PHONE 2 🞎 CELL 🞎 HOME 🞎 WORK | | PREFERRED METHOD OF CONTACT | | | 🞎 PHONE 1 🞎 EMAIL  🞎 PHONE 2 | |
| PLACE OF EMPLOYMENT | | POSITION | | | | |
| Are there family circumstances that would be helpful to share with your child’s therapist?  (e.g., custody arrangements) |  | | | | | |
| Are there any other languages spoken in the home? If yes, which language(s) and how often? |  | | | | | |
| Do any other family members have speech, language, or related difficulties or disorders?  (e.g., ADHD, autism) | RELATION TO CHILD | RELATED DIAGNOSIS/DISORDER | | | | |
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| **CHILD’S HEALTH BACKGROUND** | | | | | | | | |
| Describe your pregnancy, including any complications. | |  | | | | | | |
| Describe your labor/delivery, including any complications. | |  | | | | | | |
| TYPE OF BIRTH (check all that apply) | | | 🞎 Spontaneous (not induced) 🞎 Induced 🞎 Vaginal 🞎 C-section | | | | | |
| BIRTH PLACE (hospital/birth center) | | |  | | BIRTH ATTENDANT (physician, midwife) | | |  |
| GESTATIONAL AGE (in weeks) |  | | BIRTH WEIGHT | | BIRTH LENGTH | NICU 🞎 Yes 🞎 No How long? | | |
| Were there any complications after birth or duringthe first few weeks? | | 🞎 Difficulty breathing 🞎 Difficulty feeding 🞎 Birth defect  🞎 Jaundice 🞎 Seizures 🞎 Other: | | | | | | |
| Has your child’s hearing been tested? | | | 🞎 Yes 🞎 No | If yes, when and where? | | | 🞎 Passed 🞎 Did not pass | |
| Describe any serious illnesses, injuries, or medical procedures your child has experienced. | |  | | | | | | |
| List any environmental or  food allergies. | |  | | | | | | |
| List any routine medications  your child is currently taking  or has taken long term. | |  | | | | | | |
| Describe any other conditions  or diagnoses identified  by your child’s doctor  or other professionals. | |  | | | | | | |

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| **CHILD’S FEEDING DEVELOPMENT** | | | | |
| BREASTFED from \_\_\_\_\_\_\_ months until \_\_\_\_\_\_\_ months | | FORMULA FED from \_\_\_\_\_\_\_ months until \_\_\_\_\_\_\_ months | | BOTTLE until \_\_\_\_\_\_\_ |
| At what age did your child begin using the following? | 🞎 SIPPY CUP \_\_\_\_\_\_\_ months 🞎 STRAW \_\_\_\_\_\_\_ months  🞎 OPEN CUP \_\_\_\_\_\_\_ months 🞎 UTENSILS \_\_\_\_\_\_\_ months | | | |
| Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc. |  | | | |
| FAVORITE FOODS | | | FOOD AVERSIONS | |

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| **CHILD’S SPEECH AND LANGUAGE DEVELOPMENT** | |
| At what age did your child begin: | 🞎 BABBLING (bababa) \_\_\_\_\_\_\_ months 🞎 JARGON (bada bama) \_\_\_\_\_\_\_ months  🞎 FIRST WORD\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_ months 🞎 TWO-WORD COMBO (more milk) \_\_\_\_\_\_\_ months  🞎 THREE-WORD COMBO \_\_\_\_\_\_\_ months/years 🞎 SENTENCES \_\_\_\_\_\_\_ months/years  🞎 READING LETTERS \_\_\_\_\_\_\_ years 🞎 WRITING LETTERS \_\_\_\_\_\_\_ years  🞎 READING WORDS \_\_\_\_\_\_\_ years 🞎 WRITING WORDS \_\_\_\_\_\_\_ years  🞎 READING SENTENCES \_\_\_\_\_\_\_ years 🞎 WRITING SENTENCES \_\_\_\_\_\_\_ years |
| Who understands your child’s speech, and how much do they understand? 25% = 1 out of 4 words understood  50% = 2 out of 4 words understood  75% = 3 out of 4 words understood  100% = 4 out of 4 words understood | 🞎 Parent(s) 🞎 Sibling(s) 🞎 Peers 🞎 Teacher(s) 🞎 Extended Family 🞎 Strangers  \_\_\_\_\_\_% \_\_\_\_\_\_% \_\_\_\_\_\_% \_\_\_\_\_\_% \_\_\_\_\_\_% \_\_\_\_\_\_% |
| Has your child’s speech-language been evaluated before?  If yes, please note the place  and summarize the findings. |  |
| What are a few specific goals or skills you would like your child to attain in speech therapy? |  |
| Is your child aware of his/her communication difficulties?  Do you wish to share information with your child, such as goals or diagnosis? |  |

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| **CHILD’S STRENGTHS AND FAVORITES** | |
| Describe your child’s strongest skills and personality traits.  What makes your child unique? |  |
| FAVORITE ACTIVITIES / HOBBIES |  |
| FAVORITE TOYS |  |
| FAVORITE MOVIES |  |
| FAVORITE BOOKS |  |

Thank you for taking the time to complete this information about your child.

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PARENT/GUARDIAN SIGNATURE DATE