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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 YOUR MAIN CONCERNSInclude 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 services your 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 during the 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 medicationsyour child is currently takingor 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 understood100% = 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 placeand 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