RESULTS
SPEECH & LANGUAGE
THERAPY, PLLC
connect to grow

Child Intake Form / History

Today's Date __________

Client Name: ____________________________ Nickname: ____________

Date of Birth: ______________ Age: _________ Pronouns: _____________

Diagnosis (if 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 / Guardian 1 Name: ____________________________________

Best Contact Information: _____________________________________

Parent / Guardian 2 Name: ____________________________________

Best Contact Information: _____________________________________

What adults does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)

☐Grandparent(s) ☐Both Parents ☐Parent 1 Only

☐Parent 2 Only ☐Other: ____

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

Child 1 Name: ___________Age: __ Speech Issues:_________________

Child 2 Name: ___________ Age: __ Speech Issues:_________________

Child 3 Name: ____________ Age: __ Speech Issues:__________________

Child 4 Name: ____________ Age: __ Speech Issues:__________________

Child 5 Name: ____________ Age: __ Speech Issues:__________________

Language(s) spoken in the home: ______________________________________

Who speaks the other language(s)? ____________________________________

Describe the child's use/understanding of the language(s): __________________

____

Is there anything additional you would like to share about the family / home environment? ____

____

____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: ____

____

____

____

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: ____

____

____

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: ______________________

____

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At what age did you first notice the problem? _________________________

How do the child's communication difficulties impact the family? ___________

____

____

If anyone else in the family has a speech or language diagnosis, please describe it:

____

____

____

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

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____

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:

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Birth Parent’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: ____

4. What was the birth parent’s age at the time of delivery? ____ years

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. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

4. 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: ______________________________

☐ Sleep issues Describe: ______________________________

☐ Tongue tie Describe: ______________________________

☐ Tonsillitis Describe: ______________________________

☐ Tonsillectomy Describe:______________________________

☐ Traumatic brain injury Describe: ______________________________

☐ Vision issues Describe: ______________________________

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

Please describe: ____

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Has the child ever had surgery? ☐ Yes ☐ No

Please describe: ____

____

____

Has the child ever been hospitalized: ☐ Yes ☐ No

Please describe: ____

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____

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: ____

Medication 4: ____

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

Describe: ____

____

____

Does the child currently use any equipment? (communication device, walker, etc.)
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: ______________________________

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____

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 / Psychiatrist ____

☐Vision Therapist ____

☐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: ___________________________________

____

____

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 day(s) do they attend? ______________________________________

What is their grade level: ____

Type of classroom: ____

If they receive any accommodations, please describe: ___________________

____

____

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

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Social History

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

____

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Please describe the communication difficulties the child faces in the home environment:
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Describe any significant events or changes within the home: ____________

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What are the child's strengths? ____________________________________

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What are the child's weaknesses? _________________________________

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What are the child's favorite activities? ______________________________

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____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _________________________

Does the child become easily frustrated with certain activities? If so, please explain:

Describe how the child interacts with other children: ___________________

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

What are your goals for the child over the next 5 years? ________________

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

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Person filling out the form: ____

Relationship to the child: ____

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