Speech and Language Intake #1

General Information:

Name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone: ______________________

City: ______________________ Zip Code: ______________________

Does the child live with both parents? ______________________

Mother's Name: ______________________ Age: ______________________

Mother's Occupation: ______________________ Cell Phone: ______________________

Mother's email address: ______________________ Home Phone: ______________________

Work Phone: ______________________

Level of school completed (circle one): *high school* *college* *graduate degree*

Father's Name: ______________________ Age: ______________________

Father's Occupation: ______________________ Cell Phone: ______________________

Father's email address: ______________________ Home Phone: ______________________

Work Phone: ______________________

Level of school completed (circle one): *high school* *college* *graduate degree*

Referred by: ______________________

Pediatrician: ______________________ Phone: ______________________

Address: ______________________

Brothers and Sisters (include names and ages):

Others living in the home (include phone and email address where appropriate (e.g. babysitters, etc.):

What languages does your child speak? What is your child's dominant language and are any other language spoken at home?

With whom does your child spend most of his or her time?

Describe your child's speech-language problem.

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is your child aware of the problem? If yes, how does he or she feel about it?

Have any other speech-language specialists seen your child? Who and when? What were their conclusions or suggestions? Please provide evaluation reports if applicable.

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen your child? If yes, indicate the type of specialist and when the child was seen. Please provide a copy of evaluation reports.

Please provide a chronology of services obtained (i.e. Birth to Three, preschool, etc.)

Are there any other speech, language, hearing, learning, or psychiatric problems or disabilities in your family? If yes, please describe.

Please list other services your child currently receives (i.e. OT, PT, etc.)

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc.)

Mother's general health prior to pregnancy (food allergies, auto immune disorders, etc.)

Length of pregnancy: ____________________ Length of labor: ____________________

General condition: ____________________ Birth weight: ____________________

Type of delivery (circle): *head first* *feet first* *breech* *Caesarian*

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Has your child experienced the following illnesses and conditions? If so, at what age?

Asthma ______	Chicken pox ______	Colds ______
Croup ______	Dizziness ______	Draining ear ______
Ear infections ______	Encephalitis ______	German measles ______
Headaches ______	High fever ______	Influenza ______
Mastoiditis ______	Measles ______	Meningitis ______
Mumps ______	Pneumonia ______	Seizures ______
Sinusitis ______	Tinnitus ______	Tonsillitis ______

Other ______________________________

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Does your child have any allergies? If yes, identify.

Is your child on a special diet? If yes, describe.

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl ______________________ Sit ______________________ Stand ______________________

Walk ______________________ Feed self ________________ Dress self ________________

Use toilet ___________________

Use single words (e.g., no, mom, doggie) ______________________________________

Combine words (e.g., me go, daddy shoe) ______________________________________

Name simple objects (e.g. , dog, car, tree) ______________________________________

Use simple questions (e.g., Where's doggie?) ___________________________________

Engage in a conversation ____

Do you recall anything remarkable with regards to development (i.e. loss of words, anxiety, etc.)?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

Do you find your child to be anxious, sad, or irritable?

How does your child sleep?

Is your child sensitive to touch, textures, smells, certain foods, clothes, etc.?

Does your child exhibit any unusual behaviors or have unusual interests?

Educational History

School: ____ Grade: ____________

Teacher(s): ____

How is your child doing academically (or preacademically)?

How does the child interact with others (e.g., shy aggressive, uncooperative)?

Number of regular playmates: ______ Ages: ____________ Genders: ____________

Activities shared with parents and siblings: ________________________________

How does your child handle frustration: ____________________________________

conflict: __________________________ separation: _______________________

Regular responsibilities: ____

Favorite places: _______________________ people: ______________________

toys: ______________________________ snacks: ______________________

activities: ___________________________ TV programs: ________________

What motivates your child most? ____

What discipline methods work best? ____

If enrolled for special education services, has an Individualized Educational Plan (IEP), or other specialized plan been developed? If yes, what services are included? Please provide copy of IEP or plan.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: ______________________ Relationship to client: ______________

Signed: ____________________________________ Date: ____________________________