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CLIENT INTAKE FORM

Please provide the following information to help the therapist evaluate and recommend appropriate treatment for your child. If you are unsure how to answer a question, leave it blank to discuss with the therapist.

ABOUT YOUR CHILD:

NAME:_____
LAST FIRST MI NAME CHILD GOES BY

DATE OF BIRTH:_____ AGE:_____ GENDER:_____ RACE: _____

_____
STREET APT OR UNIT # CITY STATE ZIP COUNTY

INSURANCE: BCBS MEDICAID NONE GROUP #: _____ POLICY #:_____

MEDICAID #: _____

REASON FOR COMING TO CLINIC:

What are your concerns? What prompted to seek speech/language therapy for your child?

_____

_____

How did you hear about us? _____

IMPORTANT INFORMATION:

Who were you referred by? _____

Name of Primary Care Doctor _____ Phone: _____

What other therapies does your child receive? _____

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CONTACT INFORMATION:

PARENT/CAREGIVER 1

NAME: _____ RELATIONSHIP TO CHILD: _____
LAST FIRST

ADDRESS (if different from child): _____
STREET APT OR UNIT #

_____
CITY STATE ZIP COUNTY

CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____

PARENT CAREGIVER 2

NAME: _____ RELATIONSHIP TO CHILD: _____
LAST FIRST

ADDRESS (if different from child): _____
STREET APT OR UNIT #

_____
CITY STATE ZIP COUNTY

CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____

SIBLINGS (both blood and by marriage):

_____

_____

Who currently lives in the home with your child? _____

Is the child adopted or in foster care? YES NO

If YES, please explain: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP TO CHILD: _____

PHONE: _____ EMAIL: _____

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PREGNANCY AND BIRTH:

☐ CHECK IF BIRTH HISTORY UNKNOWN

When was your child born (number of weeks)? _____
At time of birth, how old was: Mother: _____ Father: _____
How many: Miscarriages? ____ Stillbirths? _____
Any problems during pregnancy?
If yes, please explain: _____
_____
_____

DURING PREGNANCY, DID MOTHER TAKE:
Prescription medications: _____
Vitamins or supplements: _____
Drugs: YES NO If YES, list: _____
Smoke: YES NO If YES, how many packs per day? _____
Alcohol: YES NO If YES, how much? _____
Was child born in the US? YES NO If NO, where? _____
Was child born: VAGINALLY C-SECTION
If C-SECTION, why: _____

Any problems during delivery? YES NO
If YES, please explain:_____

CHILD'S DEVELOPMENT:

WHEN DID YOUR CHILD FIRST:

Roll Over:	NOT YET	EARLY	ON TIME	LATE
Sit Without Support:	NOT YET	EARLY	ON TIME	LATE
Crawl:	NOT YET	EARLY	ON TIME	LATE
Walk:	NOT YET	EARLY	ON TIME	LATE
Make Cooing/Pleasure Sounds:	NOT YET	EARLY	ON TIME	LATE
Babble:	NOT YET	EARLY	ON TIME	LATE
Use First Word:	NOT YET	EARLY	ON TIME	LATE
Drank from Open Cup:	NOT YET	EARLY	ON TIME	LATE

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Drank from Straw:	NOT YET	EARLY	ON TIME	LATE
Finger feed:	NOT YET	EARLY	ON TIME	LATE
Eat with spoon:	NOT YET	EARLY	ON TIME	LATE

How old was your child when you first became concerned about their communication, behavior, etc? _____

What were you most concerned about at that time? _____

Did your child ever stop doing any skills that he/she had learned? YES NO
If YES, please explain: _____
_____

HOW DOES YOUR CHILD LET YOU KNOW WHAT HE/SHE WANTS OR NEEDS?
Please circle all that apply.

Looking at Objects	Pointing at Objects	Gestures
Crying	Making sounds	Touch/Grab
Single Words	2–3 Words	Sentences

Are you worried about your child's social or play skills? YES NO
If YES, please explain: _____

Does your child have any dietary restrictions or allergies? YES NO
If YES, please explain: _____

COMMUNICATION HISTORY:
Estimate the number of single words your child uses consistently: _____
Estimate the length (# of words) of your child's utterances (single words, 2 or 3 word sentences, short phrases or sentences):_____

What percentage of what your child says, do you understand? _____
What percentage do family members understand? _____
Unfamiliar people? _____

Can your child understand and follow simple directions? YES NO
Does your child turn their head when their name is said? YES NO

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Does your child ask "wh" questions (who, what, etc.) appropriately? YES NO
Does your child answer "wh" questions appropriately? YES NO

Does your child have difficulty pronouncing certain kinds of words? YES NO
Explain: _____

Does your child get "stuck" or "stutter" when speaking? YES NO
Explain: _____

Do you have concerns about your child's voice? (hoarse, breathy, etc) YES NO
Explain: _____

What is the primary language spoken in the home? _____
Are there any other languages the child is exposed to? _____

PLEASE CIRCLE ANY EXISTING DIAGNOSES GIVEN BY A *MEDICAL PROFESSIONAL* (doctor, psychiatrist, psychologist, speech-language pathologist, audiologist, occupational therapist, etc.)

Autism	Down Syndrome	Learning Disability
ADHD	Emotional Disorder	Rhett's Syndrome
Cerebral Palsy	Fragile X	Seizures
Cleft Lip	Genetic Disorder (other)	Vision Impairment
Cleft Palate	Hearing Impairment	Other: _____
Chronic Ear Infection	Intellectual Disability	Other: _____

Further information on indicated diagnoses:

_____

_____

_____

FAMILY HISTORY:

Mother's Name: _____ Occupation: _____
History of Speech, Language, or Learning problems (or in family)? YES NO
If YES, please explain: _____

Father's Name: _____ Occupation: _____
History of Speech, Language, or Learning problems (or in family)? YES NO
If YES, please explain: _____

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ENT HISTORY:

Last hearing screening/evaluation: _____ PASS or FAIL
If Fail, explain: _____
Has your child ever had PE tubes? YES NO
If yes, does your child still have PE tubes? YES NO
For how long? _____
Have they ever needed to be replaced? YES NO
Has your child ever had vocal cord impairment? YES NO
If yes, explain: _____
Has your child's vision ever been screened/evaluated? YES NO
If yes, explain: _____

HAS YOUR CHILD HAD ANY FEEDING DIFFICULTIES? *(circle all that apply)*

Sucking or Nursing
Excessive length of time to drink a bottle
Regurgitation of liquids or solids through nose
Difficulty chewing/swallowing
Choking and/or gagging

Does your child drool more than other children his/her age? YES NO
Did your child have difficulty gaining weight as an infant? YES NO

Social/Emotional Development:

CIRCLE BEHAVIORS THAT YOUR CHILD EXHIBITS:

Overly quiet	Overly active	Excessive tantrums	Destructive
Friendly, outgoing	Kicking	Hitting	Biting
Defiant	Runs away	Prefers adults	Picky Eater

Other: _____

CIRCLE THE PHRASES THAT DESCRIBE YOUR CHILD'S PLAY:

Putting toys in mouth	Banging toys together	Throwing toys
Pushing/pulling toys	Uses toys appropriately	Role-playing games
Make Believe play	Plays games with rules	Rough and tumble play

Other: _____

Describe any evaluations or therapy for behavioral or emotional difficulties:
_____

Educational History:

Did/does your child attend daycare or preschool? YES NO
If yes, where and how often? _____

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Did/does your child receive Early Intervention Services? YES NO
If YES, for how long and how often? _____

Name of child's school and grade (if applicable):_____

List any special education services, support services, or accommodations your child has received at school:_____

Are there any family circumstances you feel we should know about? (e.g, new baby, divorce, separation, recent death in the family)

_____

_____

Any Additional Concerns:_____

_____

We greatly appreciate your time in completing this form. We look forward to working with your family!