Speech-Language Initial Intake Form

The information you provide will enable your speech-language pathologist to plan the most appropriate evaluation or therapy services. If you should have any questions, please contact your service provider. Thank you.

Date: _____

Patient's Name: _____

☐ Male ☐ Female

Patient's Date of Birth: _____

Parent/Guardian Name(s): _____

Relationship to Patient: _____

Address: _____

_____

Who does the patient live with? ☐ mother ☐ father ☐ other _____

Best Way to Contact: (check all that apply)

☐ home phone _____
☐ cell phone _____
☐ email _____

What is the reason you are seeking speech-language services for your child?

_____

_____

_____

_____

Has your child been given a diagnosis by a physician? ☐ Yes ☐ No

If yes, what diagnosis has been given?

_____

_____

Physician's Name: _____

Physician's Phone : _____

Please provide the following information about your child's siblings:

Name	Age	Gender	Grade Level	Diagnoses/ Concerns

Speech-Language-Hearing

Is there a language other than English spoken in the home? ☐ Yes ☐ No
Does the child speak the language? ☐ Yes ☐ No
Does the child understand the language? ☐ Yes ☐ No
Who speaks the language? _____
Which language does the child prefer to speak at home?
_____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No
If yes, where and when? _____
What were you told?
_____
_____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No
If yes, where and when? _____
What were you told?
_____
_____

Has your child ever had speech therapy? ☐ Yes ☐ No
If yes, where and when? _____
What was he/she working on?
_____
_____
_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe.

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?

_____

_____

Medical History

Has your child had any of the following?

☐ hearing loss
☐ seizures
☐ cleft palate
☐ brain injury
☐ intellectual disability
☐ autism spectrum disorder

Birth History/Development

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe.

_____

_____

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe.

_____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed at the hospital, please describe why and how long.

_____

_____

Is your son/daugther adopted? ☐ Yes ☐ No

Please list any medications or supplements your child takes regularly:

_____

_____

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ babbled
_____ said first words
_____ walked
_____ combined words
_____ spoke in short sentences
_____ used signs (if baby sign was taught)
_____ toilet trained

Does your child...

☐ choke on food or liquids? ☐ currently put toys/objects in his/her mouth? ☐ bite ☐ brush his/her teeth and/or allow brushing?

Your child primarily communicates using...

☐ crying/whining/screaming ☐ gesture/body language ☐ sounds (vowels, grunting). ☐ words (shoe, doggy, up). ☐ 2 to 4 word sentences. ☐ sentences longer than four words. ☐ other

_____

Behavioral Characteristics:

☐ cooperative ☐ attentive ☐ willing to try new activities ☐ plays alone for reasonable length of time ☐ separation difficulties ☐ easily frustrated/impulsive ☐ stubborn ☐ poor eye contact ☐ easily distracted/short attention ☐ destructive/aggressive ☐ withdrawn ☐ self-abusive behavior

If your child is in school, please answer the following:

Name of school and grade in school:

_____

_____

_____

Please attach copies of the following:

(Please check the box for those that have been provided.)

☐ most recent speech-language evaluation
☐ developmental pediatrician report (if applicable)
☐ IFSP/IEP goals
☐ speech-language progress report