A Sound Approach Speech/Language Therapy, LLC
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Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
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 **A Sound Approach Speech/Language Therapy, LLC**?
_____

Family Background
Parent 1 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Parent 2 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
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: __ Sex: __ Speech Issues:_____
Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 3 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 4 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 5 Name: _____ Age: __ Sex: __ Speech Issues:_____

Language(s) are 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: _____
_____
_____
_____
_____

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? _____
_____
_____

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:
_____
_____
_____
_____
_____
_____
_____
_____

Mother'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 mother'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: _____
_____
_____

Has the child ever had surgery? ☐ Yes ☐ No
Please describe: _____
_____
_____

Has the child ever been hospitalized: ☐ Yes ☐ No
Please describe: _____
_____
_____

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: _____
_____
_____

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 / Psychologist _____
☐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
☐Aggression
☐Answering simple questions
☐ Understanding people
☐ Excessive drooling
☐Producing speech sounds
☐Reading
☐Remembering
☐Transitions
☐Frustration Tolerance
☐Anger
☐ Answering –wh questions
☐ Following directions
☐Chewing or eating
☐Stuttering
☐School work
☐Maintaining eye contact
☐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:
_____
_____
_____
_____

Social History
Describe how the child interacts with parents, siblings, or other family members:
_____
_____
_____

Please describe the communication difficulties the child faces in the home environment:
_____
_____
_____
_____

Describe any significant events or changes within the home: _____
_____
_____

What are the child's strengths? _____
_____
_____
_____

What are the child's weaknesses? _____
_____
_____
_____

What are the child's favorite activities? _____
_____
_____
_____

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?
_____
_____
_____
_____
_____
_____

Person filling out the form: _____
Relationship to the child: _____