Achievement Therapy Center, LLC

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Speech/Language Intake **Patient Name**_____

What age did your child demonstrate the following (estimate):

_____ Cooing, pleasure sounds _____ Babbling (ba-da, da-da) ____ Jargon (own special language)

_____ Single Words _____ Phrases (go bye-bye, more juice) _____ Short sentences

Does your child...

___ repeat sounds, words or phrases over and over?

___ understand what you are saying?

___ retrieve/point to common objects upon request (ball, cup, shoe)?

___ follow simple directions (“Shut the door” or “Get your shoes”)?

___ respond correctly to yes/no questions?

___ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

___ body language ___sounds (vowels, grunting) ____words (shoe, doggy, up) ____2 to 4 word sentences

_____sentences longer than four words other _____

How often would you say you understand your child’s speech? Less than 50% of the time ____ 50%-75% of the time _____ 75%-100% of the time _____

Has your child received or been evaluated for any other therapies? No _____ Yes____ Where, when, and for what therapy? _____

Results of evaluation? _____

Oral / Feeding

Any feeding problems as an infant? Y N Was he/she colicky? Y N If yes, for how long

When did your child transition to spoon feeding? ____ Did he/she tolerate: ___ Stage one

___ Stage two ____Stage three _____ Mixed textures ____ Fork mashed ___Meltables

Any history of the following:

Neurological:

___ CNS Anomaly ___ Trauma ___ Seizures ___ Hydrocephalus
___ Microcephaly ___ Meningitis ___ Cerebral palsy

Respiratory:

___ Pneumonia ___ Bronchiolitis ___ Sinusitis ___ BPD (bronchopulmonary dysplasia)

___ Apnea ___ Laryngomalacia ___ Tracheomalacia ___ Stridor
___ Oxygen _____ %, duration needed _____ ___ Ventilator

Gastrointestinal:

___ GERD ___ Esophagitis ___ Failure to Thrive ___ Short Gut Syndrome ___

Constipation ___ Vomiting ___ Formula Changes

Does your child avoid any foods?

Does your child seem overly sensitive to smells? Y N What

types of foods does your child like?

Does your child have any feeding/swallowing problems? Y N If yes, please describe

Behavior/Temperament

Please describe your child's personality

How do you handle behavior problems or tantrums at your house?

Does your child have tantrums Y N How often? Is your child an early riser or slow to get going?
Does your child like a routine? Y N
Is he/she bothered by breaks in routine? Y N
Can your child play alone? Y N
Does your child play alone all of the time? Y N
Who does your child prefer to play with
Does your child demonstrate self-stimulating behaviors? Y N If yes, please describe

Does your child sleep through the night? Y N Does your child wake during the night? Y N
Does your child sleep in their own bed? Y N Does your child have difficulty going to sleep? Y N
What are your child's favorite toys?
Where does he/she like to play?
Does your child have any favorite games or activities?