



**Pediatric & Adult Therapy Services, LLC**  
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## Child Intake Form / History

Client Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
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 **Pediatric & Adult Therapy Services, 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:

\_\_\_\_\_

\_\_\_\_\_

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*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

Frustration Tolerance

Aggression

Anger

Answering simple questions

Answering –wh questions

Understanding people

Following directions

Excessive drooling

Chewing or eating

Producing speech sounds

Stuttering

Reading

School work

Remembering

Maintaining eye contact

Transitions

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: \_\_\_\_\_