Clermont Speech and Language Therapy Center
Intake Sheet Form
www.ClermontSpeechLanguage.com
Phone: 352-432-3960 Fax: 352-708-5524

Person filling out form: ______________________________ Relationship to child: ________________________

Child Name: ____ Date of Birth: __________________________

Address:____ City:_______________ State_____ Zip______

Email:____

Phone: _______________________________ Best # to reach you on appt. date: ________________________

Parent/Legal Guardian Names:____

Child lives with both parents? YES NO If no, with whom? ____

Referring Physician/Person: _____________________________________

Reason for Referral: ____

____

Pediatrician: ____ Phone:____________________________

History of Problem

Describe present problem: ____

____

____

Who noted present problem? __________________________________ When? _________________________

Has there been any significant change in last six months?_______ If so, what?__________________________

____

Previous evaluations (list):____

Diagnosis: ____________________________________ Made by: ______________________ When:_________

Has your child received any therapy to date (list): Y__ N__ How long?_________ By whom? __________

How well is your child understood by: (i.e., what percentage of time) Mom:________ Dad:___________
Younger Siblings:_____Older Siblings:______Other Children:______Extended Family_____ Unfamiliar
Adults:______

PRENATAL/BIRTH HISTORY

Full Term: YES or NO. If no, how many weeks?____

Birth Weight: _______________________ Delivery: Vaginal Cesarean Breech Feet First

Illnesses or accidents during pregnancy: ____

Medications used during pregnancy:____

What was the length of the labor?_____________ Mothers health during pregnancy?_____________

Was labor induced or spontaneous?____

Was fetal distress noted? ___________________Was oxygen required?_______________________

Did the child have problems breathing at birth? ____

Sucking? ________________ Fed via breast, bottle or Non-Oral? ____________________________

DEVELOPMENTAL HISTORY

Has your child had any feeding difficulties? Check each item that applies.

☐Sucking or nursing ☐Excessive length of time to drink bottle

☐ Difficulty chewing or swallowing meats ☐Regurgitation of liquids or solids through the nose

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

_______ Sat up alone _______Crawled _______ Walked _______ Make wants known

_______ Eat pureed fruits/veggies _______ Eat pureed meats _______ Eat raw fruits/vegetables

_______ Used a straw ______ Used cup without lid ______ Attention span for self directed activities

Does your child choke while eating? Y or N If "yes", on what foods?___________________________________

Is your child a picky eater? Y or N If "yes", what foods does s/he prefer?_______________________

Does your child drool more than other children his/her age? YES or NO

Does your child have difficulty gaining weight as an infant? YES or NO

Did or does your child suck his/her thumb? ____

Does your child use a pacifier? __________What type?_________________________

LANGUAGE DEVELOPMENT

Describe what is like to have a conversation with your child: ____

____

Language(s) spoken in home:________________ Which are spoken by the child?______________

Which are understood by the child____

How many words can your child say? (List if fewer than fifteen): _____________________________________

____

Does your child have difficulty following directions? (Describe):
____

____

Any speech or hearing problems in the immediate or extended family? (explain): ________________________

____

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed) ____cooing, pleasure sounds _______ Single words______phrases (go bye-bye) _______ _____ short sentences

How long are your child's sentences?________________________________

What is the primary method(s) your child uses for letting you know what she/he wants?

☐Looking at objects ☐Crying
☐Pointing at objects ☐Vocalizing/grunting
☐Gestures ☐Physical manipulation

Which of the following best describes your child's speech?

☐Easy to understand Difficult for parents to understand
☐Difficult for others to understand/ Almost never understood by others
☐Different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

☐Is easily frustrated when not understood
☐Has been teased about their speech
☐Does not seem aware of speech/communication problem
☐Tries to say sounds or words more clearly when asked
☐Is successful in saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds YES or NO

If "yes", which ones? ____

MEDICAL HISTORY

Please check if your child had had any of the following (and if so, at what age):

☐Seizures ☐Mumps ☐Tonsillitis ☐High fevers ☐Chicken Pox ☐Meningitis ☐Measles
☐Whooping cough ☐Pneumonia ☐Diphtheria ☐Croup ☐Encephalitis ☐Rheumatic fever
☐Tuberculosis ☐Sinusitis ☐HIV ☐Enlarged glands ☐Thyroid ☐ Asthma ☐Heart trouble
☐Chronic colds

Please explain any checked items here: ____
Are immunizations current: ______________________
Has your child had any earaches/ear infections? YES or NO Please explain below:
____
____
____
Allergies?
(Describe)____
Any constipation? ______________________________ Is bowel flow/BM daily? YES or NO
Any reflux/vomiting? ____
Any other serious or recurrent illnesses?____
Any operations?____
Any accidents?____
Any medications? (Past) ____
(Present)____
Vision Problems?____
Hearing difficulties?:____
Has your child had a hearing test? __________ When? __________ By whom?______

Other Medical History? ____
____

Social Development

Name and ages of siblings:____
Other adults living in the house:____
Moves prior of 10:____
Has your child attended daycare?__________ Nursery School?________________________
Number of regular playmates:_________ Ages:___________________________Genders:_______________
Activites shared with parents and siblings:____
What motivates your child?____

Which of the following describes the type of play your child likes to engage in the most often?

☐Putting toys in mouth ☐Shaking toys Pushing/pulling toys
☐Banging toys together ☐Role-playing
☐Throwing toys ☐Acting out familiar routines
☐Games with rules ☐Rough and tumble play
☐Looking at books

What is the length of time your child can stay playing at one activity? ___________________________________

What activity seems to hold your child's attention for the longest period of time? _________________________

Which activities seem to hold your child's attention for the shortest period of time?_______________________

School History

School experience: ____

How does your child's teacher describe his/her performance? _________________________________

Has the teacher expressed any concern? If so, what?____

Other
What do you hope to have happen as results of this evaluation?________________________________
Does the report need to be sent to specific agencies?____Where?_____________________________________
Anything else you would like us to know?____
____
____

Please complete this form and fax or bring it with you (along with any relating reports (IEP, Hearing test results or other evaluation reports) to your appointment. This will speed up your intake process.

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