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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