Intake Form

Today's Date

Patient's Name

Date of Birth

Guardian Completing Form

Referring Provider

Phone Number

Home Address

Reason for Referral

Family Information & History

Name of Caregiver A

Relationship to the Child

Occupation

Address (if different from the Child)

Email

Cell Phone

Work Phone

Home Phone

Name of Caregiver B

Relationship to the Child

Occupation

Address (if different from the Child)

Email

Cell Phone

Work Phone

Home Phone

Child lives with ☐ Parent(s) ☐ Grandparent(s) ☐ Sibling(s) ☐ Other:

List family members with related speech, feeding, cognitive, physical, hearing, and/or physical disabilities

Primary Language ☐ English ☐ Spanish ☐ ASL ☐ Other:

List all languages spoken at home

Educational History

Check all that apply ☐ N/A ☐ Daycare ☐ Preschool ☐ Private ☐ Public

☐ Full-time ☐ Part-time ☐ Grade Level

Name of School

Teacher's Name

Phone Number

Permission to Contact ☐ Yes ☐ No

Does you child receive any of the following services at school or privately

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Reading Specialist
☐ Special Education ☐ Special Education ☐ Counseling ☐ Other:

Are there reports of academic or behavioral difficulties? Who reported these issues? Please describe.

Medical History

Birth History

Weeks gestation born & weight (ex. 33 weeks; 3 lbs 4 oz)

Hospital Name, City, State

List pregnancy complications (e.g., pre-eclampsia, gestational diabetes, etc).

Birth Complications (e.g., need for oxygen, fetal distress, NICU Stay, emergency c-section, etc)

Medical Team Contact Information

Provider Name

Name of Practice

Phone Number

Fax Number

Permission to Contact ☐ Yes ☐ No

Provider Name

Name of Practice

Phone Number

Fax Number

Permission to Contact ☐ Yes ☐ No

Provider Name

Name of Practice

Phone Number

Fax Number

Permission to Contact ☐ Yes ☐ No

Provider Name

Name of Practice

Phone Number

Fax Number

Permission to Contact ☐ Yes ☐ No

List other professionals working with your child

Current Medical Status

Hearing	☐ Intact	☐ Impaired	☐ Uses:
Ear Infections (yearly)	☐ Less than 3	☐ 3 to 5	☐ More than 5
Last screen/test	☐ Birth	☐ This year	☐ Other:

Vision	☐ Intact	☐ Glasses/contacts	☐ Blind
Last screen/test	☐ Birth	☐ This year	☐ Other:

Check all that apply	☐ Frequent colds	☐ Frequent Congestion	☐ History of bronchitis
	☐ Mouth breathes	☐ Snores	☐ History of sinusitis
	☐ Seasonal allergies	☐ Seen ENT	☐ Has P-E tubes
	☐ Hearing loss	☐ Tonsil removal	☐ Adenoid removal
	☐ Lip-tie release	☐ Tongue-tie release	☐ Heart problems
	☐ High fever	☐ Measles	☐ COVID-19
	☐ Frequent headaches	☐ Seizures	☐ Other:

Allergies	☐ Dairy	☐ Soy	☐ Gluten
	☐ Egg	☐ Nut	☐ Other:

Medications	☐ Yes	☐ No	*Share prescription information*

Hospitalization	☐ Yes	☐ No	*If so, when?*

List reasons

Behavioral History

Check all that apply	☐ Nervousness	☐ Hyperactive	☐ Poor concentration
	☐ Sleepless	☐ Wets bed	☐ Nightmares/terrors
	☐ Sad	☐ Shy	☐ Easily upset
	☐ Destructive	☐ Aggressive	☐ Head-banging
	☐ Rocking	☐ Flapping	☐ Self-stimulation
	☐ Anxiety	☐ Sensitive to sounds	☐ Doesn't notice noises
	☐ Dislikes touch	☐ Likes to touch	☐ Perseverates
	☐ Prefers movement	☐ Likes routines	☐ Others:

Developmental History

Motor Milestones

Sits independently	☐ Yes	☐ No	*If so, when did s/he start ?*
Crawls	☐ Yes	☐ No	*If so, when did s/he start ?*
Walks	☐ Yes	☐ No	*If so, when did s/he start ?*
Jumps (2ft)	☐ Yes	☐ No	*If so, when did s/he start ?*

Check all that apply	☐ Trips easily	☐ Falls often	☐ Clumsy
	☐ Difficulty with stairs	☐ Difficulty grasping	☐ Needs help dressing
	☐ Cannot ride a bike	☐ Difficulty using utensils	

Feeding Milestones

Breast	☐ Latched immediately following birth
	☐ Difficulty latching from the start, but figured it out
	☐ Difficulty latching from the start, unsuccessful with breastfeeding
	☐ Uses/Used nipple shield
	☐ Uses/used finger feeder
	☐ Uses/used syringe
	☐ Uses/used SNS

List all bottles or feeding systems attempted to date

Add any additional information regarding previous treatment with IBCLC or other feeding professional

Eats cut-up table foods	☐ Yes	☐ No	*If so, when did s/he start ?*
Drinks from straw cup	☐ Yes	☐ No	*If so, when did s/he start ?*
Drinks from open cup	☐ Yes	☐ No	*If so, when did s/he start ?*
Independently uses spoon/fork	☐ Yes	☐ No	*If so, when did s/he start ?*

Weaned from breast	☐ Yes	☐ No	☐ Not offered	*If so, when did s/he start ?*
Weaned from bottle	☐ Yes	☐ No	☐ Not offered	*If so, when did s/he start ?*
Weaned from pacifier	☐ Yes	☐ No	☐ Not offered	*If so, when did s/he start ?*
Weaned from sippy cup	☐ Yes	☐ No	☐ Not offered	*If so, when did s/he start ?*

Check all that apply	☐ Finger sucking	☐ Nail biting	☐ Lip biting
	☐ Lip licking	☐ Lip sucking	☐ Object chewing
	☐ Clenching teeth	☐ Grinding teeth	☐ Extended paci use
	☐ Excessive drooling	☐ Low appetite	☐ Extended sippy use
	☐ Low volume of food	☐ Feeding tube	☐ Reflux
	☐ Noisy eater	☐ Messy eater	☐ Takes large bites
	☐ Takes small bites	☐ Coughs/chokes	☐ Hiccups after eating
	☐ Eats <10 foods	☐ Eats <20 foods	☐ Difficulty chewing
	☐ Burps often	☐ Texture preference	☐ Flavor preference

Where does your child sit during meals?	☐ Infant seat	☐ High chair	☐ Booster
	☐ Caregiver's arms	☐ Regular chair	☐ Stands
	☐ Wanders	☐ Caregiver's lap	☐ Sofa
	☐ Crib	☐ Bed	☐ Car seat

Utensils	☐ Syringe	☐ Open Cup	☐ Nosey Cup
	☐ Straw Cup	☐ Bottle	☐ Breast
	☐ Sippy Cup	☐ Straw	☐ Infa-trainer
	☐ Spoon	☐ Fork	☐ Grip
	☐ Plate Guard	☐ Divided Plate	☐ Other:

Ate first birthday cake?	☐ Yes	☐ No

Elaborate feeding concerns

Speech & Language Milestones

Babbles (baba)	☐ Yes	☐ No	*If so, when did s/he start ?*
Jargons (long strings)	☐ Yes	☐ No	*If so, when did s/he start ?*
Speaks meaningful words	☐ Yes	☐ No	*If so, when did s/he start ?*
Combines words (more ball)	☐ Yes	☐ No	*If so, when did s/he start ?*

Understands	☐ Most of what I say	☐ Some of what I say	☐ Nothing I say
Communicates using	☐ Uses words	☐ Uses gestures	☐ Uses photos
Pronunciation	☐ No problem	☐ Slight problem	☐ Hard to understand
Awareness of Difficulties	☐ Aware	☐ Not aware	
Regression in skills	☐ Yes	☐ No	*If so, explain?*

Describe your speech and/or language concerns.

Rate (0%, 25%, 50%, 75%, 100%) how well your child is understood by:

_____ *You*	_____ *Spouse*	_____ *Siblings*
_____ *Peers*	_____ *Teachers*	_____ *Strangers*

Social History

What opportunities does your child have playing with other children his/her age?

My child prefers to	☐ play alone.	☐ play with others.

List favorite toys, movies, TV shows

Upcoming Visit

Areas of concern	☐ Speech	☐ Stuttering	☐ Language	☐ Feeding	☐ Swallowing
	☐ Oral Motor	☐ Fine Motor	☐ Gross Motor	☐ Sensory	☐ Handwriting
	☐ Self-care	☐ Self-regulation		Other:	

What are you hoping to gain from an evaluation or therapy? Explain

Name of Caregiver Completing Form *Signature* *Date*