



At The Lake Therapy – Intake Form

Please complete and submit this form prior to your child's evaluation. This will provide the therapist adequate time to review information and select appropriate assessment material.
This form may be filled out by hand or online.

General Information

Name: _____ Date of Birth: _____ Age: ____

Nicknames: _____ Gender: ____

Address: _____ Phone: _____

City: _____ Zip: _____

Person completing form: _____

Who is at home?

Adult #1 Name: _____ Age: _____

Occupation: _____ Phone: _____

Email: _____

Relationship to Child: _____

Adult #2 Name: _____ Age: _____

Occupation: _____ Phone: _____

Email: _____

Relationship to Child: _____

How would you like to be contacted? _____

Other members of the house:

Name	Relationship	Age	Note

Referred by: _____ Phone: _____

Pediatrician: _____ Phone: _____

Address: _____

Family members with Speech, Language, Hearing, or Learning difficulties?

Family Member	Difficulty

What languages does the child speak? What languages does the child understand? What is the child's dominant language?

Language	Understand	Speak	Dominant

What languages are spoken in the home? What is the dominant language spoken?

With whom does the child spend most of his or her time?

Describe the child's speech-language problem (Grammar, sounds, etc).

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any therapy specialists seen the child (Physical Therapist, Occupational Therapist, ABA, etc.)? Who and when?

Therapy	Where	Times a week	Length of sessions
PT			
OT			
ABA			
Other:			
Other:			

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? Please elaborate.

Please fill out the following chart about the child's speech and language development milestones.

Skill	Age	Skill	Age
Babbling		First sentence	
First word		Conversation engagement	
2 words together			

Longest sentence/phrase/babble the child has said:

Prenatal and Birth History

Birth Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Prescriptions/non prescriptions taken during pregnancy: _____

Length of pregnancy : _____ Birth weight: _____

Circle type of delivery: Vaginal/ Planned Cesarean / Emergency Caesarean / Breach /

Other: _____

Any complications prior or during delivery?

Current Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma _____	Chicken pox _____	Colds _____
Croup _____	Dizziness _____	Draining ear _____
Ear infections _____	Encephalitis _____	German measles _____
Headaches _____	High fever _____	Influenza _____
Mastoiditis _____	Measles _____	Meningitis _____
Mumps _____	Pneumonia _____	Seizures _____
Sinusitis _____	Tinnitus _____	Tonsillitis _____
Other _____		

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications or allergies? If yes, please identify.

Are vaccination records current? **YES/NO**

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl _____	Sit _____	Stand _____
Walk _____	Feed self _____	Dress self _____
Use toilet _____		

Does your child do the following?

Name simple objects (e.g., dog, car, tree) _____ Examples: _____

Use simple questions (e.g., Where's doggie?) _____ Examples: _____

Bottle-Fed or Breast-Fed Weaned off Bottle age: _____

Where there difficulties feeding? _____

Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

Does your child have any formal diagnosis? When and where were they diagnosed?

Diagnosis	Where diagnosed?	When diagnosed

Hearing Evaluation Date: _____ PASS/FAIL

History of Ear Infections YES/NO PE Tubes YES/NO

Vision Evaluation Date: _____ PASS/FAIL

Educational History

Daycare / Preschool / T-K / School / Home School

School: _____ Grade: _____

Teacher(s): _____

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (Extended Family, Siblings, Adults, Non-Family Children) (e.g., shy, aggressive, uncooperative)?

If enrolled for special education services, has an IEP or IFSP been developed?

(If yes, please have a copy of the IEP/IFSP available)

Child's favorite Activity: _____

Child's least favorite Activity: _____

Extra-Curricular Activities: _____

Please provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: _____

Relationship to client: _____

Signed: _____ Date: _____