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 Cesarian / Emergency Caesarian / Breach /
Oher: _____
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.

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-FedWeaned 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: _____