



CLIENT INTAKE FORM

KATESAID SPEECH THERAPY

FOR OFFICE USE

CLIENT ID:

SCHOOL/PROGRAM:

FORM COMPLETED BY: DATE:

RELATIONSHIP TO CLIENT: PHONE:

EMAIL ADDRESS:

HOME ADDRESS:

PREFERRED METHOD OF CONTACT: CALL TEXT EMAIL

PERSONAL INFORMATION (CLIENT)

FIRST NAME: LAST NAME:

MALE FEMALE NON-BINARY PRONOUNS

DOB: RACE/ETHNIC GROUP:

ADDRESS (CHECK IF SAME AS ABOVE):

HOBBIES/INTERESTS:

HOME SETTING

PARENT/CAREGIVER (1): RELATIONSHIP:

EMAIL: PHONE:

OCCUPATION:

PARENT/CAREGIVER (2): RELATIONSHIP:

EMAIL: PHONE:

OCCUPATION:

PRIMARY LANGUAGE(S) SPOKEN IN THE HOME:

WITH WHOM DOES THE CLIENT LIVE? PLEASE INDICATE RELATIONSHIP:



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MEDICAL & DEVELOPMENTAL HISTORY

PLEASE LIST ANY MEDICAL DIAGNOSES (INCLUDE DATES):

[Text input area for medical diagnoses]

WERE THERE ANY PROBLEMS DURING PREGNANCY/BIRTH? YES NO

*IF YES TO THE ABOVE OR UNKNOWN, PLEASE EXPLAIN:

[Text input area for pregnancy/birth explanation]

HAS THE CLIENT EXPERIENCED ANY HEARING PROBLEMS? YES NO

*IF YES TO THE ABOVE OR UNKNOWN, PLEASE EXPLAIN:

[Text input area for hearing problems explanation]

HOW OLD WAS THE CLIENT WHEN THEY BEGAN TO WALK? [Text input area]

HOW OLD WAS THE CLIENT WHEN THEY SPOKE THEIR FIRST WORDS? [Text input area]

HOW OLD WAS THE CLIENT WHEN THEY BEGAN TO EAT SOLID FOODS? [Text input area]

PLEASE LIST ANY MEDICATIONS, VITAMINS, AND/OR SUPPLEMENTS THAT THE CLIENT IS CURRENTLY TAKING:

[Text input area for medications/supplements]

PLEASE LIST ANY ALLERGIES THE CLIENT HAS (IF ANY):

[Text input area for allergies]

IF THE CLIENT HAS HAD ANY OF THE FOLLOWING, PLEASE CHECK BELOW*

- EARLY INTERVENTION PHYSICAL THERAPY COUNSELING
 OCCUPATIONAL THERAPY BEHAVIORAL THERAPY TUBES IN EARS
 VISUAL IMPAIRMENT SENSORY PROBLEMS OTHER

*IF CHECKED ABOVE, PLEASE EXPLAIN:

[Text input area for explanation of checked items]

PLEASE DESCRIBE ANY SERIOUS ACCIDENTS, SURGERIES AND/OR ILLNESSES

[Text input area for accidents/surgeries/illnesses]



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EDUCATIONAL HISTORY

SCHOOLS/ACADEMIC PROGRAMS ATTENDED (PLEASE INCLUDE DURATION):

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CURRENT ACADEMIC GRADE/LEVEL:

[Blank grey rectangular box for text entry]

DOES THE CLIENT READ? YES NO WRITE? YES NO

THE CLIENT HAD/HAS AN IFSP, IEP, OR 504 PLAN? YES* NO

*IF YES TO THE ABOVE, PLEASE EXPLAIN ACCOMMODATIONS (IF ANY):

[Two blank grey rectangular boxes for text entry]

HAS THE CLIENT RECEIVED SKILLED SERVICES IN THEIR SCHOOL OR PROGRAM? (I.E. SPEECH, OCCUPATIONAL THERAPY, ETC.) YES* NO

*IF YES TO THE ABOVE, PLEASE EXPLAIN TYPE AND DURATION OF SERVICE:

[Two blank grey rectangular boxes for text entry]

WHAT IS THE CLIENT'S MOST FAVORITE SUBJECT/TASK?

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WHAT IS THE CLIENT'S LEAST FAVORITE SUBJECT/TASK?

[Blank grey rectangular box for text entry]

DO YOU HAVE ANY CONCERNS ABOUT THE CLIENT'S ACADEMIC PERFORMANCE? IF YES, PLEASE EXPLAIN:

[Two blank grey rectangular boxes for text entry]

SPEECH & LANGUAGE

PLEASE SELECT THE CLIENT'S PRIMARY MODE(S) OF COMMUNICATION:

- VERBAL LANGUAGE SOME WORDS VOCALIZATIONS
- MANUAL SIGNS/ASL GESTURES PHYSICAL DIRECTING
- AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) *OTHER (PLEASE DESCRIBE)

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SPEECH & LANGUAGE (CONTINUED)

IS THE CLIENT USUALLY UNDERSTOOD BY UNFAMILIAR INDIVIDUALS? YES NO SOMETIMES

IS THE CLIENT APPEAR FRUSTRATED BY THEIR COMMUNICATIONS? YES NO SOMETIMES

PLEASE SELECT THE FOLLOWING THAT APPLY TO THE CLIENT. DO THEY:

MAKE REQUESTS FOR ITEMS YES NO

ASK QUESTIONS YES NO

ASK FOR HELP YES NO

MAKE COMMENTS YES NO

INITIATE INTERACTIONS YES NO

STAY ON THE TOPIC OF CONVERSATION YES NO

INVITE OTHERS TO PLAY/JOIN GROUP YES NO

TAKE TURNS YES NO

PLEASE PROVIDE ANY ADDITIONAL DETAILS ABOUT THE WAY THE CLIENT COMMUNICATES/ITERACTS WITH OTHERS:

IS THE CLIENT CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED SPEECH THERAPY SERVICES? YES* NO

*IF YES TO THE ABOVE, PLEASE EXPLAIN WHAT THEY WERE WORKING ON AND THE DURATION ON SERVICE:

PLEASE DESCRIBE THE CLIENT'S STRENGTHS:

PLEASE DESCRIBE ANY PRESENT CONCERNS:

PLEASE DESCRIBE THE GOALS YOU HAVE FOR THE CLIENT. WHAT WOULD YOU LIKE TO SEE THEM WORK ON?



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ADDITIONAL COMMENTS

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT WOULD BE PERTINENT TO WORKING WITH THE CLIENT AND THEIR FAMILY:

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.
PLEASE EMAIL COMPLETED FOR TO [KATE@KATE-SAID.COM](mailto:kate@kate-said.com) WITH THE
CLIENT'S NAME & "INTAKE FORM" (i.e. JOHN DOE INTAKE FORM)**

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