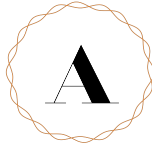

ADVANCED
THERAPY SOLUTIONS

120 N Perkins Road STE F Stillwater, OK 74075❖405.564.2701❖www.ats-stillwater.com

Diagnostic Intake form for Children

Speech/Language

Today's Date: ________________________________

Child

Name:__________________________________ ☐ Male ☐ Female

Date of Birth: ___________________________

Age: ___________________________________

Home Address: ____

City, State, Zip: ____

Phone: ____

E-mail: ____

Referred by: ____

Parent(s) / Guardian(s)

Mother: __________________ Occupation: _______________ Day Phone:______________

Address (if different from above):____

Father: __________________ Occupation: _______________ Day Phone:_______________

Address (if different from above):____

Other People in the Household:

Name __________________Age ______ Relationship _________________________

Name _________________ Age ______ Relationship _________________________

Name _________________ Age ______ Relationship _________________________

Insurance:

Primary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Secondary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Please check the appropriate box below:

I, the undersigned, □ certify □ do NOT certify that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to **Advanced Therapy Solutions, LLC** all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Advanced Therapy Solutions, LLC** to release all information necessary to secure the payment of benefits.

History of Speech/Language Problems

1. Describe your concern regarding you child's speech and/or language in your own words:

____

____

2. At what age was this problem first noticed?______________________________________

3. Who first noticed the problem? ____

4. How has the problem changed since that time? __________________________________

____

5. Do you have difficulty understanding your child? ________________________________

6. Do other people have difficulty understanding your child? Please describe: __________

____

7. Has your child previously been assessed for speech/language concerns? □ Yes □ No

If so, describe: ____

____

8. Has your child received any prior speech/language therapy? □ Yes □ No

   If so, where? ___________________________ By whom?______________________________

   For how long?__________________________ Focus of Treatment: __________________________

   Results of Treatment: ____

9. Does you child receive other services (or has he/she in the past)? Counseling; psychiatry; occupational or physical therapy? □ Yes □ No

   If so, where? ___________________________ By whom?______________________________

   For how long?__________________________ Focus of Treatment: __________________________

   Results of Treatment: ____

10. Have any other family members had speech/language problems or related disorders?

   (e.g. Autism, ASHD) □ Yes □ No

   Indicate the person's relationship to the child and the nature of the problem.

   Relationship:_________________ Nature of Problem:______________________________

Medical History and Current Health Status

1. Was there anything remarkable about the mother's health during pregnancy or delivery?

____

2. Was there anything remarkable about the child's condition at birth?

____

3. Does the child have developmental concerns other than the speech/language problem?

   □ Yes □ No

   Describe ____

4. At approximately what age did your child begin to:

   Babble ________________ Sit up ___________________________Crawl_______________________

   Walk ___________________ Use words__________________ Combine words________________

5. Has your child experienced ear infections? □ Yes □ No

   Approximately how often (check one)? □ Rarely □ Occasionally □ Frequently

   Has your child's hearing ever been tested? □ Yes □ No / Results ______________________

   Do you feel your child hears normally? □ Yes □ No / Explain __________________________

6. Indicate if your child has experienced the following medical problems:

Chicken Pox _______________ Tonsillitis _________________ Vision Problems__________

Pneumonia ________________ Headaches ________________ High Fever _______________

Seizures __________________ Allergies__________________ Asthma ___________________

7. Describe illnesses, accidents, injuries, hospitalizations (include age/treatment):

____

____

8. How often do the following behaviors occur? (O = Often, S = Sometimes, N = Never)

a. Inattentiveness O S N

b. Hyperactivity O S N

c. Nervousness O S N

d. Sensitivity O S N

e. Perfectionism O S N

f. Excitability O S N

g. Frustration O S N

h. Strong fears O S N

i. Excessive neatness O S N

j. Excessive shyness O S N

k. Lack of confidence O S N

l. Competitiveness O S N

9. What is your child's current health status? □ good □ fair □ poor

10. Please list your child's current medications (including vitamins, over-the-counter medications):

Medication	**Dose**	**How Often**

11. Does your child have any other medical diagnoses or concerns? Please describe:

____

____

12. Does your child have any allergies? □ Yes □ No

Please specify all allergies (environmental and food): ______________________________

Speech and Language Skills

1. Is your child aware of his/her difficulty with speech and/or language skills?

2. Has your child ever demonstrated any of the following:

□ Awareness of inability to communicate

□ Gives up when trying to communicate

□ Frustration about speaking

□ Complaints that s/he "can't talk"

Describe: ____

____

2. Has your child ever been teased about his/her speech or language? □ Yes □ No

Describe: ____

____

3. Has your child ever discussed his/her speaking difficulties with you? □ Yes □ No

Describe: ____

____

4. Rate how often your child is able to communicate his/her thoughts and ideas in the following situations (circle one in each column):

At Home	At School	In New Situations
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

5. How does the child's speech and/or language affect his or her:

Academic performance? ____

Participation in school activities? ____

Interaction with other children? ____

Interaction with family members? ____

Willingness to talk and communicate? ____

Self-esteem or attitude toward self? ____

6. Who understands your child's speech, and how much do they understand?

□ Parent(s)	How much do they understand? ________%
□ Sibling(s)	How much do they understand? ________%
□ Teacher(s)	How much do they understand? ________%
□ Peers	How much do they understand? ________%
□ Extended Family	How much do they understand? ________%
□ Strangers	How much do they understand? ________%

7. What else do you think we should know about your child (e.g., hobbies, interests, social skills)? ____

- Favorite toys/books/movies/shows: ______________________________________

8. What are a few specific goals or skills you would like your child to attain in speech therapy? ____

Would you like to receive a courtesy reminder for every scheduled appointment? (circle)

Yes *or* ***No***

-If yes, what type of reminder do you prefer? ***E-mail*** ***Text*** ***Call***

Please provide the phone number or e-mail address where you would like to receive reminders: ____

Thank you for taking the time to complete this information about your child!

____ ___________________

Signature of Parent or Guardian Date