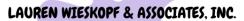
Date: \_\_\_\_\_\_ 1



PEDIATRIC SPEECH-LANGUAGE PATHOLOGY SERVICES (770) 330-4513

## **Initial Intake Form**

## **Personal Information**

Child's Name:	Date of Birth:	
Preferred Name:	Age:	
Home Address:	Zip Code:	
Parent 1: Phone Number and Email:		
Age and Occupation:		
Parent 2: Phone Number and Email:		
Age and Occupation:		
Who referred you to our practice?:		
Address of Referral (If Professional):		
Reason(s) for Referral:		
Child's Primary Care Doctor Name:		
Primary Care Doctor's Address:		
Primary Care Doctor's Phone Number:		
Person(s) Responsible for Payment:		
Name of Person Filling Out This Questionnaire:		

Primary Language(s) Spoken in Your Home:
Additional Language(s) That Your Child Speak(s) if Applicable:
Description of Concern(s)
Please check the statement(s) below that describe your concern(s) regarding your child's
speech and language development:
Language (e.g. delayed development, limited vocabulary, poor sentence structure, word
retrieval difficulties, difficulty understanding or remembering what people say, processing
difficulties, etc.)
Articulation (e.g. pronunciation of sounds and/or words)
Fluency (e.g. stuttering and/or stammering. Does your child hesitate, 'get stuck', repeat
or stutter on sounds and or words?)
Voice (e.g. hoarse, strained, nasal quality, etc.)
Further describe the nature of your concern(s):
Has your child's teacher(s) expressed any concern(s) about your child's school performance,
interaction with teachers/peers, and/or speech and language skills? Yes No
If yes, please explain:
Has your child ever received: (check all that apply)
☐ Speech/language evaluation
☐ Speech/language therapy
☐ Both

If applicable, who did your child see and for how long?:
Results (if applicable):
Does your child ever get frustrated by his/her difficulties? If yes, please explain:
Does your child ever avoid speaking in certain situations? If yes, please explain:
Do any relatives have speech and/or language difficulties?: (check all that apply)  ☐ Yes ☐ No
If yes, what is the relationship to your child?:
If applicable, what are/were those difficulties?:
<u>Developmental History</u>
Were there any complications during pregnancy and/or delivery? If yes, please explain:
Do you feel that your child's developmental milestones (e.g. sitting, crawling, walking, etc.) occurred within normal limits? If no, please explain:

Which is your child's dominant hand?:
☐ Right
☐ Left
☐ Ambidextrous
Do you have any concerns with your child's coordination? If yes, please explain:
Medical History
Is your child's health good? fair? or poor?
Is your child currently under any medical treatment or on any medication? If yes, please
describe any treatment(s) or medication(s):
Has your child ever been seen by a neurologist or other specialist? If yes:
Name(s):
Date(s):
Result(s):
Has your child ever had an ear infection? If yes, when was the last one?:
Has your child ever had any surgical procedures for hearing or infections? If yes, please explain:
Has your child ever had a hearing test? If so, when and what were the results?:

Describe any illnesses, accidents, in	juries, operations, and	d/or hospitalizations that your child
has had:		
Speech and Language Developme	<u>ent</u>	
Did your child make babbling and or	cooing sounds during	the first 6 months after birth?:
☐ Yes		
□ No		
At what age did your child say his/he	er first word?:	
What are a few examples of your ch	ild's first words vocaliz	zed?:
Did your shild continue to add words	anno ha/aha atartad	to talk?
Did your child continue to add words	once ne/sne started i	to taik?.
☐ Yes		
□ No		
At what age did your child begin usin	ng two to three-word s	entences?:
Did your child's speech/language de	velopment ever halt fo	or a period of time?:
☐ Yes		
□ No		
Does your child talk frequently?	occasionally?	or never?
Does your child prefer to: (check all	that apply)	
☐ Talk		
☐ Gesture		

☐ Both (talk and gesture)
To communicate, does your child most frequently use: (check all that apply)
☐ Sounds
☐ Single words
☐ Two to three-word sentences
☐ 3+ word sentences
Does your child make any sounds incorrectly? If so, which sounds?:
Describe any recent changes that you have noticed in your child's speech and/or language:
Can your child sing/say a nursery rhyme?:
☐ Yes
□ No
Can your child tell a simple story?:
☐ Yes
□ No
Can your child describe events of the day?:
☐ Yes
□ No
How well can your child be understood by his/her caregivers?:
Others?:
Does your child understand what is said to him/her?:
☐ Yes
□ No

Can your child follow directions?:
☐ Yes
□ No
Does your child ever have difficulty remembering what has been said to him/her? If so, when
does this happen?:
Daily Behavior
How well does your child get along with other children/peers?
If your child reads, does he/she like to read?:  If applicable, what does your child like to read?:  Does your child like to be read to?:
Check all that apply to your child: (explain and give ages if possible)
☐ Concerns with eating:
☐ Drooling:
☐ Sleeping difficulties:
☐ Thumb sucking/pacifier usage:
☐ Difficulty concentrating:
☐ Requires additional disciplining:
☐ Underactive:
□ Overactive:
☐ Sensitive (emotionally and/or sensory):
☐ Difficulty getting along with other children/peers:
☐ Difficulty getting along with adults:
☐ Emotional:

☐ Irritable:
☐ Other:
Educational History
Does your child attend school?
☐ Yes
□ No
If yes, please answer all questions below:
Name of school:
Address of school:
Grade/Level:
Does your child enjoy school? Please explain:
What subject(s) does your child excel in?:
What subject(s) does your child demonstrate weakness in?:
Does your child receive any special assistance at school? If yes, please explain:
What is your overall impression of your child's learning abilities?:
Has your child ever received psychological and/or special education evaluations or services?:
Specialist Address: (if applicable)
Date(s) of evaluation and or services: (if applicable)

Thank you for sharing this information with us!