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?:

_____

Developmental History

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, injuries, operations, and/or hospitalizations that your child has had:

_____

_____

Speech and Language Development

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/her first word?: _____

What are a few examples of your child's first words vocalized?:

_____

Did your child continue to add words once he/she started to talk?:

- ☐ Yes
- ☐ No

At what age did your child begin using two to three-word sentences?: _____

Did your child's speech/language development ever halt for 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) _____

Family

Please list other children in your immediate family, including their age and school if applicable:

_____

_____

What kinds of activities does your family enjoy doing together? Please explain:

_____

_____

What activities does your child particularly enjoy/excel in? Please explain:

_____

_____

Is there any further information you feel would be helpful for us to know in regard to evaluating and/or treating your child? If so, please explain:

_____

_____

Thank you for sharing this information with us!