
Speech Therapy Intake Form

Client Information

Date: _____

Person completing form: _____ **Relationship to child:** _____

Child's Name: _____ **Child's Date of Birth:** _____

Gender: _____ **How did you hear about our clinic?** _____

When was your child first diagnosed with the condition, or developmental delay? Has there been any changes in the past 6 months in regard to the diagnosis (i.e. worsening or new development of symptoms)?

Does your child have any other problems or diagnoses that may be influencing their development?

Has your child ever been seen by a speech therapist? If yes, please explain.

Has your child been seen or are they currently being seen by a speech therapist or any other specialists? If yes, please explain.

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If yes, please explain.

What language(s) does your child speak?

What language is spoken most often at home? What other languages are spoken in the home?

How does your child communicate (e.g. gestures, sign language, single words, phrases, sentences)?

Developmental History

Provide the approximate age at which your child began to do the following: (leave blank if not performed yet)

Hold Head Up _____ Sit _____ Crawl _____

Babble _____ Feed Self _____

Use two-word phrases _____ Use simple questions _____

Child's physical development has been: **FAST** **NORMAL** **SLOW**

Child's speech and language has been: **FAST** **NORMAL** **SLOW**

Has your child ever had any feeding problems? If yes, please describe.

When was your child's last hearing screening?

ear infection (approximate age of first ear infection) _____

tube in ears: _____

allergies: _____

seizures: _____

medication use: _____

Are there any medical precautions the therapist should be aware of when working with your child?
