Child Speech Intake

First Name:  Middle Initial:  Last Name: 

Address: City/State/Zip: 

Email address(s):  

Phone #:  Home / Work/ Cell Date of Birth: 

Phone#:  Home / Work/ Cell Social Security #:

Race:  Sex: 

|  |
| --- |
| Emergency Contact:  Phone:  Relationship: |

Primary Care Doctor: Referring doctor: 

Address/Phone#:  Address/Phone#: 

Reason for referral: 

**Insurance information**

Policy holder(s) Name:  DOB: 

Plan Name:  Insurance ID#: 

Secondary Insurance: (leave blank if none)

Plan Name:  Insurance ID#: 

Mother’s Health During Pregnancy

Mother's age at time of delivery? Was there any stress during the pregnancy?  Y  N

If yes, please explain: 

Were there any infections or illnesses during pregnancy or delivery?    Y  N

If yes, please explain: 

How many weeks gestation was the child born? (40 weeks is typical)

Delivery was:   Vaginal      Cesarean Section

Child was   lbs  oz and  inches at birth

List any complications or concerns with labor or delivery: 

**Medical History**

Patient’s Current Weight:   Height: 

Is your child up to date with immunizations?  Y  N

\*\*Please list all Current Medications, the strength and how often they are prescribed in the columns below\*\*

 None

|  |  |  |
| --- | --- | --- |
| Medication | Strength | How many/How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Medication | Strength | How many/How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

\*\*Please list all allergies to medications, foods, and or environmental along with reaction\*\*

 No Known allergies

|  |  |
| --- | --- |
| Allergic to | Reaction |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Has the client had an audiological evaluation (hearing test)?  Y  N

If yes, please provide by whom and the approx. date of evaluation: 

Were the results normal?

 Y  N If no, please explain: 

History of ear infections:  Y  N Occurrence of ear infections: 

If “yes”, approx. how many ear infections to date: Date of last ear infection: 

Please explain course of treatment:



Has the client had previous Speech and Language Assessments?  Y  N

If yes, please provide by whom and approx. date:

Has the client had previous Speech and Language Services?  Y  N

If yes, please provide by whom and approx. date:

|  |
| --- |
| Current medical problems:  Past medical problems, nonpsychiatric hospitalization, or surgeries:  Who does the child live with?     Does the child have siblings or are there other siblings in the home?  Y  N  If yes, please list below   Child 1 Name: Age:      Sex:   Speech Issues:     Child 2 Name:  Age:       Sex:   Speech Issues:    Child 3 Name:  Age:       Sex:   Speech Issues:    Child 4 Name:  Age:        Sex:   Speech Issues: |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Condition | Patient | Family |  |  |  | | Asthma |  |  |  |  |  | | Adenoidectomy |  |  |  |  |  | | Autism |  |  |  |  |  | | Attention Deficit Hyperactivity Disorder |  |  |  |  |  | | Attention Deficit Disorder |  |  |  |  |  | | Behavior Issues |  |  |  |  |  | | Brain Injury |  |  |  |  |  | | Breathing problems |  |  |  |  |  | | Cardiac issues |  |  |  |  |  | | Chicken Pox |  |  |  |  |  | | Diabetes |  |  |  |  |  | | Ear infection |  |  |  |  |  | | Ear tubes |  |  |  |  |  | | Encephalitis |  |  |  |  |  | | Frequent colds |  |  |  |  |  | | High Fever |  |  |  |  |  | | Measles |  |  |  |  |  | | Meningitis |  |  |  |  |  | | Mumps |  |  |  |  |  | | Seizures |  |  |  |  |  | | Sensory issues |  |  |  |  |  | | Sleep issues |  |  |  |  |  | | Tongue tie |  |  |  |  |  | | Tonsillitis |  |  |  |  |  | | Tonsillectomy |  |  |  |  |  | | Traumatic Brain Injury |  |  |  |  |  | | Vision Issues |  |  |  |  |  |   Is there any additional personal or family medical history?  Y  N If yes, please explain:    Has the child ever had surgery?    Y  N  If yes, please list the date of surgery and type below:    Has the child ever been hospitalized?   Y  N  If yes, please list the date(s) and reason below    Has the child ever been in a serious accident?   Y  N  If yes, please describe below    Does the child have any chronic illnesses?   Y  N  If yes, please describe below    Does the child currently use any equipment? (Communication device, walker, etc.)  Y  N  If yes, please list below       Describe the child current health status:       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Is the child currently receiving any of the following services?   If yes, please list the name of the provider and last date of service     |  |  |  | | --- | --- | --- | | Type of service: | Name | Dates of service | | Developmental Pediatrician |  |  | | Neurologist |  |  | | PT |  |  | | OT |  |  | | SLP |  |  | | Behavioral Therapist |  |  | | Educational consultant |  |  | | Psychologist/Psychiatrist |  |  | | Vision Therapist |  |  | | Other |  |  |     **Developmental History**    At what age did the child do the following:   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | Crawl | | |  |  | |  | Sat Up | | |  |  | |  | Stood | |  |  | |  | Walked | | | |  |  | |  | Fed Self | | | | | |  |  | |  | Dress Self | | | | | | |  |  | |  | Toileted | | | | |  |  | |  | Single Words | | | | | | | |  |  | |  | Combined Words | | | | | | | |     Does the child do any of the following:   |  | | --- | | Choke on liquids | | Choke on foods | | Avoid foods | | Maintain a special diet | | Use a pacifier/suck thumb | | Mouth objects |   If the child is under the age of 4, how many words does the child say:  0-20   21-50  51-100  101-151   151-300  301-500  500+  Does the child produce sentences of the following length:  2 words    3 words    4 words    5+ words  What % of the child speech do you understand?  How well do people outside of the family understand the child speech, give a %?   Does the child have any difficulty with the following:          None   |  |  |  | | --- | --- | --- | | Attention | Aggression | Answering simple questions | | Understanding people | Excessive drooling | Producing speech sounds | | Reading | Remembering | Transitions | | Frustration Tolerance | Anger | Answering -wh questions | | Following directions | Chewing or eating | Stuttering | | School work | Maintaining eye contact | Word retrieval | | Other: | Other: | Other: |    Please give a brief description of any difficulty marked below:    Has the child experienced any difficulty with feeding or swallowing?   Y  N  If yes, please describe below          **Educational History**   Is the child currently enrolled in daycare or school?  Y  N  If yes, list below the name of the program/school that the child attends, days, and times they attend and what grade level    Please describe any educational difficulties or learning challenges that this child has faced?    **Social History**    Describe how the child interacts with parents, siblings, or other family members:    Please describe any communication difficulties the child faces in the home environment:    Describe any significant events or changes within the home:    Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication/behavior?  Y  N    Does the child become easily frustrated with certain activities?   Y  N  If so, please explain below    Describe how the child interact with other children?    List the child's strengths?    List the child's weaknesses?    List the child's favorite activities?          **Goals**   What are your goals for the child over the next 6 months?    What are your goals for the child over the next 5 years? |   Please list any other information that you feel is important for us to know: | |