Speech Therapy Intake Form - Child

Client Information

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

Child's name: _____ DOB: _____ Gender: _____

How did you hear about our clinic? _____

Thank you for taking the time to fill out this form as completely and accurately as possible. We value your role in the evaluation process to help us determine the most appropriate treatment for your child. All responses are confidential and will not be released without your permission. Please answer to the best of your knowledge and mark "N/A" for any questions that do not apply to your child.

Medical Information

Child's primary care physician: _____ Date of last doctor's visit (approx.): _____

Is your child currently under the care of any other medical specialists such as a neurologist or audiologist?

If so, please list: _____

Please list any medical diagnoses your child has: _____

Please list any medications your child currently takes: _____

Please list any allergies your child has: _____

Please describe any developmental delays your child is currently experiencing or has experienced in the past *(such as delays with walking, saying first words, potty training, etc.)*:_____

_____

Were there any birth or pregnancy complications? _____

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If so, please describe: _____

_____

Social/Educational Information

Does your child attend school or daycare? _____ Current grade: _____ Grades repeated? _____

School or daycare name: _____

Special services received at school *(such as special education classes, speech therapy, occupational therapy, physical therapy)*: _____

Special services received outside of school *(such as speech therapy at a clinic, ABA therapy, hippotherapy)*:

_____

Does your child experience difficulties at school (socially or academically)? If so, please describe:_____

_____

Has your child's teacher mentioned concerns about his/her speech/language skills, social skills, behavior, or academics? _____

Family Information

Mother's Name: _____ Best contact phone #: _____

Father's Name: _____ Best contact phone #: _____

If applicable, please list other family members who regularly care for your child: _____

_____

Please list family members that your child lives with, including siblings and their ages:

_____

_____

Which language(s) is/are spoken in the home? _____

Which language(s) does your child speak? _____

Speech/Language/Swallowing

Please describe specific speech, language or swallowing concerns in the appropriate answer section below.

Do you have concerns about the way your child pronounces words, or about your child's ability to be understood? _____

Does your child have difficulty understanding what is said to him/her?_____

_____

Does your child have difficulty expressing him/herself *(such as forgetting words, using incorrect grammar, or difficulty retelling a story)?* _____

_____

Does your child stutter or repeat words multiple times when trying to speak? _____

_____

Do you have concerns with your child's voice quality *(such as chronic hoarseness or breathiness)*?

_____

Does your child have difficulty with feeding, chewing, or swallowing? _____

_____

Is there anything else you would like us to know about your child or about your reasons for seeking speech therapy services? _____

_____

_____

Thank you!