Client Intake Form

Child's Name _____ Today's Date: _____

Parent (s) or Guardian (s) _____

Cell Phone Number (s) _____ _____

Child's Birthdate _____ Child's Age _____

Pediatrician's Name _____ Phone Number _____

Pediatrician's Fax number_____

What concern brings you to us today? _____

_____

When did you first notice there might be a problem? _____

_____

Has anyone in your family been diagnosed with a speech or language disorder before? If so, please provide any information you may have. _____

_____

_____

Has your child been diagnosed with Autism, Down Syndrome, or other developmental or learning disabilities?

_____

Was your child quieter than other children as an infant?

_____

Did your child babble when he or she was an infant? At what age did he or she start?

_____

Did your child use a variety of sounds while babbling? Please provide examples.

_____

What were your child's first words? _____

_____

At what age did your child say their first words? _____

About how many words do you think your child says?

0-20 21-50 51-100 101-150 151-200 201-300 301-400 401-500

Does your child speak in phrases and sentences? _____

How many words does your child connect in a phrase or sentence?

2-words 3-words 4-words 5-words more than 5 no connected speech

Does your child seem to understand a great deal more words than he or she can say?

_____

Does your child have difficulty saying some speech sounds? If so, please list them. _____

_____

Does your child use gestures or pointing instead of speech, all or part of the time? _____

_____

Does your child seem to become frustrated or "shut down' while trying to communicate? _____

Can you think of any specific cases when this frustration regularly occurs? _____

_____ How does your child express his or her frustration? _____

_____

How do you react when this happens? _____

_____

Has your child ever used a word once and then never used it again? _____

_____

Does your child socialize (play and communicate) well with his or her friends and family? _____

_____

Do you or your immediate family have difficulty understanding your child when he or she speaks? ____

_____

Do people outside of your family have difficulty understanding your child when he or she speaks? _____

_____

When did your child meet the following developmental milestones?

Sat Up_____ Crawled_____ Stood_____ Walked_____

Potty Trained_____ Dressed Self_____ Fed Self_____

Cup Drinking_____

Does your child have a history or ear infections? _____ If so please provide more information.

_____

Does your child have any allergies? _____ If so please provide more information. _____

_____

Does your child have asthma? _____ If so please provide more information. _____

_____

Has your child ever had surgery? _____ If so please provide more information. _____

_____

Does your child have a history of chronic illness? _____ if so please provide more information.

_____

_____

Has your child ever been in a serious accident or experienced other serious injury? _____

If so please provide more information. _____

_____

Was pregnancy and deliver of your child normal? _____

_____

Has your child ever had a hearing evaluation? _____ Date _____ Results _____

_____

Has your child ever had a speech and language evaluation before? _____ If so please provide more information, and bring any documents you have to the free screening._____

_____

Has your child ever had speech and language therapy before, either through a state early intervention program, other private therapy, or through school? _____ If so please provide more information.

_____

_____

What do you hope for your child to gain from the therapy process?

_____

_____