

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 of 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?
