KidTherapy
Speech and Language Intake Form

General Information

Child's Name: _____ Birth date: _____ Age: _____
Address: _____
(Street) (City/State/Zip)
Phone: (H) _____ (W) _____ (Cell) _____
Email Address: _____
Parents: _____ Marital Status: ____ Primary Contact: _____
Mother's Occupation: _____ Father's Occupation: _____
Names and ages of siblings: _____
Emergency contact (name, relationship, phone #): _____
_____
Does your child attend (please circle): Early intervention program/preschool/grade school
Referred by (name, profession): _____
Reason for referral: _____
Insurance company (name and member ID #): _____
Pediatrician's Name: _____

Medical Information

Has your child received any previous speech and language therapy services? Yes/No
If yes, when and where: _____

Has your child received other evaluations or treatment? Yes/No (if yes, please describe)
Evaluation date Professional's name Dates of therapy____
_____
_____
_____
_____
Medical diagnosis (if any): _____
Has child had a vision/hearing test? Yes/No Results: _____
Wear glasses? Yes/No: _____

Has your child had any of the following? If yes, describe and give approximate dates.
Childhood diseases or major illnesses: _____
Congenital abnormalities: _____
Surgery: _____
Serious injury: _____
Hospitalizations: _____
Ear Infections (approximate age of first ear infection): _____
Tubes in ears: _____
Allergies: _____
Seizures: _____
Medication use: _____

Are there any medical precautions the therapist should be aware of when working with your child? Yes/No: _____

Maternal Health during pregnancy

Did the mother:

1. Have infections/illnesses during pregnancy? Yes/No
   Describe: _____
2. Have any shocks or unusual stresses during pregnancy? Yes/No
   Describe: _____
3. Receive any medication during pregnancy? Yes/No
   Describe: _____
4. Have any complications/difficulties during delivery/labor? Yes/No
   Describe: _____

Child's Birth

Was your child:

1. Full term? Yes/No Birth weight: _____
2. Premature? Yes/No Number of weeks: _____
3. Require a C-Section for delivery? Yes/No Scheduled/Emergency (circle one)
4. Require forceps/vacuum for delivery? (circle one)
5. Small for gestational age (SGA)? Yes/No
6. Breech (feet first)? Yes/No
7. Have any birth injuries? Yes/No
   Describe: _____
8. If known, Apgar score at one minute: _____ at five minutes: _____
9. Require intensive-care hospitalization? Yes/No How long? _____
10. Jaundiced? Yes/No Length of treatment: _____
11. Breast fed? Yes/No How long? _____
12. Describe any abnormalities in crying, nursing, sucking, breathing or weight gain: ___

_____

_____

Infancy and Early Childhood

Does or did you child:

1. Have feeding problems? Yes/No If yes, describe: _____

_____

_____

2. Have sleeping problems? Yes/No If yes, describe: _____

_____

3. Have colic? Yes/No If yes, describe: _____

_____

4. Prefer certain positions? Yes/No If yes, please circle: stomach/back/side/upright
5. Become calmed/nauseated with movement? (Circle one)
6. Go through the terrible two's? Yes/No
   If no, please describe your child's toddler stage: _____

_____

Developmental Milestones: Note the approximate age your child did the following:

Sat unassisted: _____ Crawled: _____
Walked: _____
Toilet trained (bladder): _____ (bowels) _____
Babbled: _____ Said first words: _____
Said 1-2 word phrases: _____ Said sentences: _____
Weaned: _____ Ate solid foods: _____

Speech and Language History

1. Is (or was) a foreign language spoken in the home? Yes/No
   If yes, is this language understood by your child? Yes/No
   is this language spoken by your child? Yes/No
2. Have your child's wants been anticipated before he could communicate the need? Yes/No

If yes, how? _____
_____

3. Does your child use extensive gestures instead of words? Yes/No
4. Does your child avoid speaking? Yes/No
5. Does your child recognize his/her own difficulty? Yes/No
6. Is your child's speech understood by: parents: Yes/No playmates: Yes/No relatives Yes/No neighbors Yes/No unfamiliar listeners: Yes/No
7. When was the speech difficulty first noticed? _____
   By whom? _____
8. Was the rate of language development: Average/Slow/Interrupted (circle one)
9. Please provide examples of your child's present speech and language skills and their ability to follow directions. _____
_____
_____
_____
10. What changes have been noticed in your child's speech and language since the difficulty was first noticed? _____
_____
_____
_____
11. How do most people react to your child's difficulty? _____
_____
_____
_____
_____

Family History

Please describe any significant family history for the following:

Speech: _____
Hearing: _____
Feeding: _____
Learning: _____
Emotional: _____
Physical: _____

Sensory Motor History

Please check any of the following areas that apply to you child:

___ Avoids being cuddled or hugged
___ Dislikes having hair and/or face washed
___ Reacts negatively to different clothing or textures
___ Falls frequently; bumps into things; accident prone
___ Tends to become easily car sick
___ Over/Under reaction to noise and music
___ Avoids activities that challenge movement and balance (swings, bicycles)

Sensory Motor History (continued)

___ Prefers tabletop activities
___ Craves movement: bouncing, swinging, merry-go-round

Academic History
Please check any of the following areas that apply to your child:
___ Poor desk posture
___ Difficulty drawing, coloring, copying and cutting
___ Poor pencil grasp
___ Reverses letters
___ Difficulty recognizing shapes, colors, letters
___ Difficulty reading
___ Decreased attention span, impulsiveness

Gross Motor History
Describe your main concern about your child's motor development. _____
_____
_____
_____

Please check any of the following areas that apply to your child:
___ Increased muscle tone or joint stiffness
___ Decreased muscle tone (floppiness) or muscle weakness
___ Asymmetry (unevenness between one side of the body and the other)
___ Preference for maintaining any joints in the same position
___ Difficulty with positioning the child in car seat, high chair, etc.
___ Decreased movement of body parts during play
___ Difficulty with skills that children of the same age are able to do (poor balance, coordination)

Additional Comments and/or Concerns
_____
_____
_____
_____
_____
_____
_____
_____