Pediatric Speech and Language Intake Form

Contact Information:

Child's Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ E-mail: _____

Preferred mode of contact: [ ] phone [ ] e-mail

Caregivers:

Relationship to child: _____ Age: _____

Occupation: _____

Relationship to child: _____ Age: _____

Occupation: _____

Siblings: (Please include age/grade level)

_____

Language(s) spoken in the home:

_____

*What are your major concerns at this time?

_____

_____

*Have you consulted any other professionals regarding these concerns?

_____

_____

Please describe your child's communication (babbling, gestures, single words, phrases, sentences, conversation)

_____

_____

Is your child difficult to understand? If so, are there particular sounds that are challenging?

_____

_____

Is your child aware of his or her problem? If so, how does he or she handle it?

_____

Is there any history of speech, language or learning challenges in your family?

_____

_____

Prenatal and Birth History:

Length of pregnancy: _____ Length of labor: _____

C-section: Yes / No Birth Weight: _____

Please note any unusual conditions that may have affected prenatal development, including mother's general health during pregnancy.

_____

Medical History:

[ ] Chronic colds/respiratory infections [ ] Chronic ear infections

[ ] Asthma [ ] Allergies [ ] High fever [ ] Influenza

Is your child taking any medications? If so, please describe duration and frequency.

Has your child been hospitalized? Has your child had any surgery?

_____

_____

Additional health information:

_____

_____

Developmental History:

Please provide the approximate age at which your child began the following

activities: Crawl_____ Sit_____ Stand_____ Walk_____

Self-feed _____Dress self_____

Point Babble_____

Use single words Name objects_____

Use phrases Use toilet_____

Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

_____

_____

Does your child have any negative reactions to sensory stimuli (i.e., noise, light, tastes, smells, touch)?

_____

_____

Describe your child's response to sound (e.g., responds to all sounds, tolerates loud noises, inconsistently responds to sounds, etc.)

_____

Does/Did your child ever use a pacifier/suck thumb or have an attachment to any other objects they put in their mouth? Yes / No

_____

Are there or have there been any feeding or eating problems (e.g., any problems with sucking, tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe.

_____

_____

From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle)

_____

Describe your child's attention level. Can your child occupy him or herself independently?

_____

_____

Does your child follow simple directions? Do you have concerns about your child's ability to understand what is being said to him/her?

_____

_____

What motivates your child most? (favorite toys, places, snacks)

_____

_____

How does your child handle frustration?

_____

_____

Does your child have regular responsibilities? Please describe.

_____

_____

Educational History:

Does your child currently attend school? Please indicate school name, grade, and schedule.

_____

_____

How is your child performing in school? Does your child enjoy school?

_____

_____

Has your child's teacher expressed any concerns?

_____

Does your child receive any special services at school? Does your child

currently have an Individualized Educational Plan (IEP)?

_____

Has your child had a speech-language evaluation/therapy, or neuro-psychological testing in the past? Please explain. What were results? Please send in a copy of testing results.

_____

_____

Does/Has your child receive any other therapy services (, feeding therapy,

occupational therapy, physical therapy)?

_____

*What is your purpose for initiating this evaluation?

_____

Thank you for taking the time to complete this form