PROFESSIONAL SPEECH SERVICES
SPEECH THERAPY

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CHILD INTAKE PACKAGE

Date: _____

PERSONAL INFORMATION:

Patient's Name: _____

Date of Birth: _____ Chronological Age: _____

Parent's Names: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

E-Mail Address: _____

I would like to receive information via e-mail (reports, billing statements, etc.) _____ Yes _____ No

FAMILY INFORMATION:

Who accompanied the patient to the evaluation: _____

Who served as informant for this case history: _____

Who lives in the home setting: _____

Names and ages of siblings: _____

If both parents are not in the home setting, how often does the child interact with the non-custodial parent? _____

Who is responsible for the child during the daytime hours, if other than the parent? _____

_____

Phone # where he/she can be reached: _____

BIRTH HISTORY

Were there any complications during pregnancy/delivery and at birth? Yes_____ No_____

If yes, please describe: _____

_____

_____

_____

MEDICAL HISTORY:

Doctor's Name: _____ Doctor's Phone #: _____

Doctor's Address: _____

_____

Does your child have any medical diagnosis? Yes _____ No _____

If yes, please list them: _____

_____

Please list any medications that your child takes regularly: _____

_____

_____

Has your child had any of the following?

☐ Adenoidectomy
☐ Allergies
Type: _____
☐ Autism Spectrum Disorders
☐ Breathing difficulties
☐ Down Syndrome
☐ Pervasive Developmental Disorder
☐ Ear infections
How Often? _____
☐ Ear Tubes
☐ Head Injury
☐ Hearing Problems
☐ Seizures
☐ Sleeping difficulties
☐ Thumb/finger sucking Habit
☐ Tonsillectomy
☐ Tonsillitis
☐ Vision problems

DEVELOPMENTAL HISTORY:

Please list the approximate age your child achieved the following developmental milestones:

Sat alone: _____
Babbled: _____
Put 2 words together: _____
Walked: _____
Grasped crayon/pencil: _____
Said first words: _____
Spoke in short sentences: _____
Was toilet trained: _____

CURRENT SPEECH-LANGUAGE-HEARING

Does your child . . . (please check all that apply)

☐ Repeat sounds, words or phrases over and over?

☐ Understand what you are saying?

☐ Retrieve/point to common objects upon request (ball, cup, shoe)?

☐ Follow simple directions ("shut the door" or "get your shoes")?

☐ Respond correctly to yes/no questions?

☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using . . .

☐ Body language

☐ Sounds (vowels, grunting)

☐ Words (she, doggy, up)

☐ 2 to 4 word sentences

☐ Sentences longer than 4 words

☐ Other: _____

List any behaviors that the therapist should be aware of (example destructive/aggressive behavior, self-abusive behavior, etc.) _____

_____

_____

Describe your child's social and play skills (with children and adults). _____

_____

_____

_____

Name and describe some toys, activities, etc. that are of particular interest to the child: _____

_____

_____

_____

Has your child received speech-language services (screenings, evaluations, or therapy)?_____

If yes, please list facility name, dates, etc.: _____

_____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, counseling, vision therapy, etc.)?_____

If yes, please describe: _____

_____

_____

SCHOOL HISTORY:

If your child is in school, please answer the following questions:

Name of school your child is currently attending: _____

What grade is your child currently in? _____

Does your child currently have an I.E.P. at school? Yes_____ No_____

If your child is home-schooled, please answer the following questions:

How many years has your child been home-schooled? _____

What is your child's current grade level? _____

What difficulties, if any, does your child have with their learning process? _____

_____

What subject(s) does your child experience more difficulty? _____

_____

The information is correct to the best of my knowledge.

_____

Signature of Patient/Legal Guardian

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_____Photo I.D. was checked to comply with the FTC rules regarding Identity Theft