Wiregrass Therapy Associates, LLC

Child Intake Form / History

Today's Date _____
Client Name: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Diagnosis (if known): _____
Address: _____
City, State, Zip: _____
Phone _____Phone_____

Emergency Contact Name: _____Relationship_____
Emergency Contact number _____

Client's Physician: _____
Physician Phone Number: _____
Physician Address: _____

Family Background

Parent 1 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Parent 2 Name: _____ Age: _____
Occupation: _____ Education Level: _____

Language(s) are spoken in the home: _____
Who speaks the other language(s)? _____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____
_____

Has the child had a previous speech, language or feeding evaluation / treatment?
☐Yes ☐No By whom: _____When: _____
Describe the results: _____

At what age did you first notice the problem? _____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____

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Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No
Describe: _____
2. Was there any stress during the pregnancy? ☐Yes ☐No
Describe: _____
3. Were there any complications during labor or delivery? ☐Yes ☐No
Describe: _____
4. What was the mother's age at the time of delivery? ____ years

Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

_____
_____

Is the child up to date with immunizations: ☐ Yes ☐ No

Has the child ever had surgery? ☐ Yes ☐ No
Please describe: _____

Has the child ever been hospitalized: ☐ Yes ☐ No
Please describe: _____

Has the child ever been in a serious accident? ☐ Yes ☐ No
Please describe: _____

Does the child have a chronic illness? If so, please describe: _____

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: _____
Medication 2: _____
Medication 3: _____

Does the child have any known allergies? ☐ Yes ☐ No
Describe: _____

Does the child have a history of ear infections, tubes, or hearing aides? ☐Yes ☐No

Does the child have any known vision or hearing loss? ☐Yes ☐No

Recent vision/hearing screen? _____

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Developmental History

At what age did the child do the following:

Sit alone: _____ Crawl: _____
Stood Up: _____ Walk: _____
Made Sounds: _____ First Word: _____
Combined Words: _____ Sentences: _____
Fed Self: _____ Understood by Others_____
Toilet Trained: _____ Dressed Self: _____

If under 4 years of age, how many words does the child say:

☐0-20 ☐21-50 ☐51-100 ☐101-150 ☐151-300 ☐301-500

Does the child produce sentences of the following length:

☐2 words ☐3 words ☐4 words ☐5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____

Does the child do any of the following:

☐Choke on liquids ☐Choke on foods
☐Avoid foods ☐Maintain a special diet
☐Use a pacifier / suck thumb ☐Mouth objects
Please describe any of the above: _____

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What are your goals for the child over the next 6 months? _____
_____