Speech Child Intake Form

The intake paperwork will take approximately 25-30 minutes for completion.
Please complete all sections prior to your first appointment.
Thank you for being a part of Speech For Success, PLLC.

**** indicates a required field***

Person Providing Information / Form Completed By:

Name :

_____

Relationship to child:

_____

Email Address:

_____

Physical Address:

_____

* What is your child's name?

_____

* What is your child's date of birth?

_____

List other family members in the home. Circle one.

None older brother/s older sister/s younger brother/s younger sister/s

Nanny grandparents

Referral source:

Self referral Doctor Other

Referring Pediatrician name and address:

Why was your child referred for an evaluation / What are your concerns?

What are your child's strengths?

What are some of your child's favorite toys /interests?

Does your child have any other Medical Diagnoses?

When was your child's most recent checkup?

Languages your child speaks and/or understands at home:

Have there been any traumatic family events in the course of the child's development, if so please describe:

Has your child had any previous speech therapy, occupational therapy, physical therapy, nutritionist, psychologist or academic support:

Adoption / Foster Placement (if applicable)

Please provide age at time of adoption / foster placement:

Prenatal / Birth History

Pregnancy (if child was adopted and this is unknown, please skip).
Check all that apply.

- [ ] Planned Pregnancy, IVF, etc.
- [ ] Complications during pregnancy for mother / length of labor
- [ ] Loss of loved one during pregnancy
- [ ] Shock? / forceps used
- [ ] Alcohol consumed during pregnancy
- [ ] Smoking during pregnancy
- [ ] Activity during pregnancy
- [ ] Medications used during pregnancy
- [ ] Delivery position
- [ ] Caesarean birth
- [ ] Birth weight
- [ ] APGAR
- [ ] Required special treatment
- [ ] Immediate physical contact with mom
- [ ] Breast fed
- [ ] Post-partum depression
- [ ] Did mother talk much
- [ ] Did mother sing during pregnancy
- [ ] Previous complicated pregnancies
- [ ] Tongue tie at birth

NICU / Special Care Nursery SCN (if applicable):

- [ ] Duration in NICU or SCN
- [ ] Diagnoses in NICU or SCN
- [ ] Treatment in NICU or SCN
- [ ] N / A

Medical History

Has your child experienced or been diagnosed with any of the following?
Check all that apply.

- [ ] Adenoid problems
- [ ] Asthma
- [ ] Bedwetting
- [ ] Birth defects
- [ ] Bowel problems
- [ ] Chicken pox
- [ ] Dental problems
- [ ] Colic
- [ ] Digestion problems
- [ ] Failure to thrive
- [ ] Frequent colds
- [ ] GERD - gastroesophageal reflux
- [ ] Head injuries
- [ ] Headaches
- [ ] Hearing loss
- [ ] High fevers
- [ ] Muscular disorder
- [ ] Nail biting
- [ ] Neurological disorder
- [ ] Nightmares / Night terrors
- [ ] Respiratory difficulties
- [ ] Sensory problems
- [ ] Skin problems
- [ ] Sleep problems
- [ ] Strep throat
- [ ] Skin problems
- [ ] Tonsilitis
- [ ] Vision problem
- [ ] Other:

Has your child seen any other medical professionals/ specialists for medical issues? If so, please list names of clinician, clinic site and date of last visit.

Autism Specialist

Audiologist

Cardiologist

Chiropractor

Early Intervention

Gastroenterologist

Geneticist

Naturopath

Neurologist

Neurodevelopmental

Nutritionist

Opthamologist

Otolaryngologist / ENT

Psychologist

Pulmunologist

Other:

At what age did your child begin to:

Sit:_____ Walk:_____ Run:_____

Speak first word:_____ Start putting words together:_____ Start using sentences: _____

Has your child had any ear infections? If so, how many?

Hearing (Check all that apply:)

- ☐ My child passed their newborn hearing screening
- ☐ My child did not pass their newborn hearing screening
- ☐ My child currently does not have problems hearing
- ☐ My child has had a formal hearing assessment
- ☐ My child has hearing device
- ☐ Other:

Vision (Check all that apply:)

- ☐ My child has good vision
- ☐ My child has had formal vision testing
- ☐ My child has experienced problems with his or her eyesight or vision
- ☐ My child has corrective lenses
- ☐ My child has never had a formal vision test
- ☐ Other:

* When was your child's last eye examination?

Date:_____ Result of eye exam:_____

Procedures: Has your child had any of the following procedures?

- ☐ No procedures
- ☐ Video floroscopic study
- ☐ Bronchoscopy
- ☐ Other:
- ☐ Upper GI / Barium Swallow

Surgeries: Has your child had any surgeries? If multiple, list separately.

_____

_____

_____

***Medication:** Is your child taking any medication or vitamins (prescribed or over the counter}. List below:

_____

_____

_____

Allergies: Does your child have any allergies or intolerances (suspected or diagnosed}? List below.

_____

_____

_____

Feeding, Speech, and Developmental History

First Year of Life:

- ☐ Breastfed
- ☐ Bottlefed
- ☐ NG tube feedings
- ☐ Thumb sucking
- ☐ Feeding problems
- ☐ Sleeping problems
- ☐ Other feeding issues:

Toddler Years - please answer age each skill developed (if not yet developed, put n/a).

Bottlefed:_____ Sippy cup:_____ Learned to walk:_____

Learned to use utensils:_____ Learned to use utensils:_____

Sleeping problems:_____ Feeding problems:_____ Toilet trained:_____

Age of first words:_____ Age started putting words together:_____

Age started sentences:_____ Other:_____

How would you describe your child's motor development?

- ☐ Normal
- ☐ Delayed
- ☐ Advanced

When learning how to speak/ communicate, did your child? (check all that apply)

- ☐ Not applicable / not speaking
- ☐ Use jumbled words / jargon
- ☐ Begin with single words, then two words, then sentences
- ☐ Did not talk for a while, then all of a sudden speak in complete sentences?
- ☐ Use a communication device
- ☐ Other speech development observations

Current Status - Feeding by Tube (if applicable)

What type of tube does your child have?

- [ ] NG
- [ ] G - Tube
- [ ] PEG - Tube
- [ ] Other:

Is feeding by bolus or drip?

- [ ] Bolus
- [ ] Drip
- [ ] Neither

Estimate child's nutrition that is given by tube:

- [ ] 100%
- [ ] 75%
- [ ] 50%
- [ ] 25%

Where is your child located when tube feedings are given?

_____

Who typically gives the tube feedings?

_____

Current Status - Eating by Mouth (if applicable)

How does your child let you know they are hungry?

_____

How many meals are offered each day?

_____

How many snacks are offered each day?

_____

Are meals and snacks offered on a schedule (the same time each day)?

Where does your child sit to eat?

- ☐ They do not prefer to sit and eat (roaming and eating)
- ☐ High Chair
- ☐ Booster Chair
- ☐ Chair at the table
- ☐ Other:

Is your child always fed in the same room?

☐ Yes ☐ No

Who is the main person feeding the child?

Who else is with your child when they are eating?

How does your child let you know they are done eating?

List the foods your child **WILL** eat and drink. List favorites first for each category:

Meats:

Vegetables:

Fruits:

Dairy:

Grains:

Liquids:

Other:

List the foods / drinks your child **REFUSES**:

Meats:

Vegetables:

Fruits:

Dairy:

Grains:

My child eats a variety of foods:

My child struggles with eating a variety:

List the foods/ drinks that your child is **ALLERGIC/ INTOLERANT** to:

Meats:

Vegetables:

Fruits:

Dairy:

Grains:

Liquids:

Other:

Feeding behaviors (check all that apply):

- [ ] Refuses bottle
- [ ] Refuses breast
- [ ] Refuses solid food
- [ ] Takes only one texture
- [ ] Eats limited variety of food
- [ ] Coughs / chokes during feeding
- [ ] Vomits during feeding
- [ ] Vomits between feeding
- [ ] Gags frequently
- [ ] Cries during feeding
- [ ] Has tantrums during feeding
- [ ] Runs away during feeding
- [ ] Throws/ spits food
- [ ] Needs to be distracted to eat
- [ ] Won't sit still to eat
- [ ] Doesn't seem hungry
- [ ] Amount eaten is unpredictable
- [ ] Seems to have pain with eating
- [ ] Seems afraid of eating
- [ ] Wakes frequently at night to feed
- [ ] Other:

Current Status - Emotional / Sensory

When given a choice, does your child prefer to play alone or with others?

- [ ] Alone
- [ ] With Others

My child's play/ peer interaction skills (check all that apply):

- [ ] Plays parallel with peers
- [ ] Imitates peers
- [ ] Take turns during games
- [ ] Shares well with other children well
- [ ] Does not share well with other children
- [ ] Initiates others to play
- [ ] Takes turns during structured games
- [ ] Has difficulty taking turns during structured play
- [ ] Can follow another peers play ideas
- [ ] Avoid peers

- [ ] Easily learns to interact with new peers
- [ ] Struggles to interact with new peers
- [ ] Seeks others to play with
- [ ] Spends inordinate amounts of time in solitary pursuits (ie: video games)
- [ ] Has unusual interests or very limited interests
- [ ] Has multiple friends
- [ ] Has been bullied

My child's emotional skills:

- [ ] Can identify likes / dislikes
- [ ] Can identify emotions in self
- [ ] Identifies emotions in others
- [ ] Demonstrates affection towards peers / others
- [ ] Demonstrates empathy towards peers / others
- [ ] Demonstrates aggressive behavior towards others
- [ ] Demonstrates aggressive behaviors towards self
- [ ] Demonstrates intense fears
- [ ] Becomes extremely anxious, has panic attacks or experiences social anxiety around others
- [ ] Shows confusion over how to make friends or respond to other people
- [ ] Displays sadness over social difficulties
- [ ] Gets angry easily
- [ ] Shows little to no empathy toward others
- [ ] Other emotional observations of child

Any specific behavior problems noted in the course of your child's development?

_____

_____

_____

Current Status - Speech

How much of your child's speech do you understand?

- ☐ 10% or less
- ☐ 11-24%
- ☐ 25-50%
- ☐ 51-74%
- ☐ 75-100%

How much of your child's speech do others understand?

- ☐ 10% or less
- ☐ 11-24%
- ☐ 25-50%
- ☐ 51-74%
- ☐ 75-100%

Does your child have difficulty producing certain sounds?

- ☐ Yes
- ☐ No

Does your child hesitate and / or repeat sounds or words?

- ☐ Yes
- ☐ No

Does your child demonstrate frustration when he/she is not understood?

_____

Education

School information (if applicable)

Name / Address:

Grade currently in:

Grade repeated, if any:

Special education classroom (self contained)

Developmental Preschool

Any Therapy Services (Speech, Occupational, Physical therapy)

Speech therapy in school

IEP / 504 plan

If child is in school, are there any concerns about academic performance (e.g., reading, writing, subject areas)?

- [ ] Yes
- [ ] No

Does your child like school? How would you describe your child's behavior at school (shy, defiant, cooperative, etc.)?

About Your Child

How would you describe your child's personality?

Is there anything else about either your child's history or current condition that you feel is important to mention?

Thank you for taking the time to fill this out.

Your therapist will review this valuable information to support the upcoming speech language assessment.

We appreciatethe time you took to complete this form.