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Intake Form

Dear Parent or Guardian:

In preparation for the scheduled evaluation, please complete this form and return it to us via email prior to meeting. This information will be held confidential. If possible, please bring in or send pictures from each year of life (preferably a close-up frontal view).

Child's Name and Preferred Nicknames:

_____

Gender (Optional):

_____

Preferred Pronouns (Optional):

_____

Birth date: _____ Age: _____

Address: _____
(No. & Street) (City & State) (Zip Code)

Pediatrician: _____
(Name, Address and Phone Number)

Who referred you to this practice?

_____

List any diagnoses: _____Date (s) of diagnoses: _____

By Whom: _____

Description of concern (s):

_____
_____
_____

FAMILY:

PARENT/CAREGIVER:

Name: _____
Address: _____
Place of Employment:_____
Occupation: _____Business Phone:_____
Cell Phone: _____Email: _____

PARENT/CAREGIVER:

Name: _____
Address: _____
Place of Employment_____
Occupation: _____ Business Phone: _____
Cell Phone: _____Email: _____

CHILDREN: List all children in order (including patient)

NAME GENDER AGE GRADE

_____
_____
_____
_____

Child is currently living with: (list all persons in the home and the relationship to the child)

_____
_____

Who will bring the child to the initial session/ongoing sessions if different from the primary caregivers? (nanny, grandparent etc.) Please provide names and phone numbers.

_____

Dominant language spoken in the home: _____
First language introduced: _____ Second language introduced: _____
Child's Dominant Language: _____

List any speech, language, hearing or learning differences on either side of the family:

_____
_____
When was the area of concern first noticed? _____
By Whom:
_____

What do you hope to gain from this evaluation?_____

_____
_____

BIRTH HISTORY:

Any illnesses during pregnancy? If yes, please share:_____
_____

Required/Recommended diet or medication during pregnancy_____
_____

Did labor come before or after the due date?_____

How early or late?_____ How long was labor?_____

Birth weight:_____

Was baby delivery head first, feet first, or cesarean?_____

Did your baby breathe and cry at birth?_____
Did your baby turn yellow?_____ Blue?_____

Did your baby have sucking or feeding difficulty?
_____

How was your baby fed? Breast_____ Bottle_____

Is there anything else you would like to share about the birth history or health of your baby at the time of delivery?

_____

DEVELOPMENTAL HISTORY:

State age when your child first:

Rolled over _____ Sat alone_____ Crawled _____ Stood alone _____

Walked alone_____ Toilet trained: Day_____Night_____

Fed self: Spoon_____ Fork_____

Brushed teeth _____Dressed self _____

Tied shoes_____

FEEDING/ORAL MOTOR:

Does your child have any eating difficulties? (i.e., messy eater, slow, fast, noisy, picky eater, etc.) Please explain.

_____
_____
_____

If difficulties are present, what types of foods does your child eat?

_____
_____
_____

Is your child a slow, fast or noisy eater? _____
Does your child prefer or avoid certain textures and/or temperatures? Please explain.

_____
_____

Describe your child's eating habits. Please check all that apply:

- ☐ Gulps food
- ☐ Chews with mouth open
- ☐ Takes large bites
- ☐ Does not chew food thoroughly
- ☐ Burps after eating/drinking
- ☐ Eats only soft foods
- ☐ Eats only crunchy foods
- ☐ Avoids mixed textures (cereal with milk)
- ☐ Has upset stomach following eating
- ☐ Washes food down
- ☐ Gags
- ☐ Sticks out tongue when eating/drinking
- ☐ Other: _____

Did/Does your child drink from a bottle? _____ Until what age? _____
Did/Does your child use a sippy cup? _____ Until what age? _____
Does your child drink from a straw successfully? _____
Does your child drink from an open cup successfully? _____
Did/Does your child use a pacifier? _____ Until what age? _____
Did/Does your child suck his/her thumb? _____Until what age? _____
Did/Does your child bite his or her lip? _____ Until what age? _____

When did/does the sucking occur (day, night, school)?

_____

Have any techniques been tried to eliminate sucking habits?

_____

What triggers did/does your child have for sucking (Check all that apply):

- ☐ Pillow
- ☐ Stuffed animal
- ☐ Blanket
- ☐ Hair
- ☐ Boredom
- ☐ Fatigue
- ☐ Fear
- ☐ Anxiety
- ☐ Car rides
- ☐ Playing inside
- ☐ Playing outside
- ☐ TV
- ☐ Homework
- ☐ Other: _____

SPEECH/LANGUAGE:

What is your child's primary mode of communication (gesture, cry, point, talk, AAC)?_____

During the first year did your child make sounds other than crying?_____

At what age did your child say words?_____

At what age did your child start to name people and objects?_____

At what age did your child combine words into short sentences such as "Want drink" or "Up Daddy"?_____

At what age did your child use more complete sentences? _____

Did your child's speech / language seem to stop developing for any period of time?_____If so, please describe:
_____
_____

Does your child understand language when spoken to?_____

Does your child follow one step directions? _____ 2 step directions? _____

Does your child point to a desired item?_____ Point to a named item to identify? _____

Does your child seem aware of a speech or language difference? _____If so, please describe:
_____
_____

Has your child received speech and/or language services in the past? If yes, for how long?
_____
_____

Has there been a change in your child's speech/language in the last six months?_____ If yes, please describe:
_____

Does your child have difficulty with specific sounds? _____ If yes, which ones _____

Does your child have hoarseness or frequently lose his or her voice? _____

Does your child stutter or have dysfluent speech? If yes, for how long and how often?

_____

MEDICAL HISTORY:

Has your child had an audiological (hearing) evaluation?_____
When?_____By Whom?_____Results:_____

Has your child ever had a serious illness or injury? If so please share when, type and outcome
_____

Has your child ever been seen by an ENT? _____
When?_____By Whom?_____
Please share any diagnoses or treatment provided by the ENT(Adenoid/tonsil shaving or removal, PE tubes, lip/lingual frenulum revisions, nasal spray)
_____

_____
Please check all that apply:

- ☐ Convulsions, spasms, seizures
- ☐ Chronic vomiting
- ☐ Chronic headache
- ☐ Serious high fevers
- ☐ Clumsiness or weakness
- ☐ Enlarged glands
- ☐ Rheumatism
- ☐ Asthma- Medication_____
- ☐ Tonsil/Adenoid Surgery- Date_____
- ☐ PE tube insertion- Date_____
- ☐ Allergies- Medication_____
- ☐ Earache/ear infection/draining ears
  How many? _____
  How often? _____
- ☐ Hearing difficulties
- ☐ Vision difficulties
- ☐ Speech difficulties
- ☐ History or sore throat
- ☐ History of sinus infections
- ☐ Bed wetting
- ☐ Frequent colds
- ☐ Nervous trouble
- ☐ Glasses
- ☐ Kidney trouble
- ☐ Lip/tongue/buccal tie- Diagnosed but not revised
- ☐ Lip/tongue/buccal revision- Date_____
- ☐ Other: _____

If you checked any of the above, please share when, how often and treatment:
_____
_____

Is your child frequently sick?_____

Has your child had any surgeries? If yes, please share:_____

Has your child ever had an EEG? _____When?_____
Where?_____ Results_____

Please list any other relevant tests_____

Does your child have allergies? _____ If yes, what is your child allergic to?
_____
What medication is your child taking?_____Dosage:_____

Is the child in good health at this time?_____ If no, please explain:_____

DENTITION:

Has your child had any teeth extracted? _____If so, how many _____
Has your child had a palate expander? _____
Are braces being considered? _____
Does your child wear a dental appliance? _____

SCHOOL:

Name of current school:_____ Address:_____
Grade:_____ Teacher:_____ Principal:_____
Age entered:_____
Has your child repeated a grade?_____ If yes, what grade?_____
Please list previous schools attended _____

Please share any concerns related to school – behaviors, academic performance, peer relations (describe in detail):
_____
_____
_____

Has your child received any special services at school?_____If yes, please share when and what services:
_____
_____

What is your child's attitude toward school?_____

Any other comments?_____
_____
_____

SOCIAL:

Describe your child's interests:_____
Does your child's play with children his/her own age?_____
Does your child have any unusual fears?_____
Is your child often nervous/anxious?_____
If yes, how do they show it?_____

Describe any behavioral concerns/challenges:_____
_____

Does your child use his/her left hand, right hand, or both?_____

Please check all that apply to your child:

- ☐ Is social and engaging
- ☐ Plays well with others
- ☐ Is aggressive
- ☐ Makes good eye contact with adults
- ☐ Is easy going
- ☐ Is oppositional
- ☐ Makes good eye contract with peers
- ☐ Does well with change
- ☐ Dislikes new people/places
- ☐ Is well behaved

- ☐ Understands safety
- ☐ Prefers to play alone
- ☐ Listens well
- ☐ Difficulties with attention
- ☐ Is very busy/active
- ☐ Follows 1-step directives
- ☐ Poor coping qualities
- ☐ Is unable to self-calm
- ☐ Follows 2-step directives
- ☐ Takes turns with peers
- ☐ Sensitive to criticism
- ☐ Has tantrums
- ☐ Quickly escalates without apparent cause
- ☐ Other: _____

Any other comments_____
_____

SLEEP:

Does your child have trouble going to bed or falling asleep? _____
Does your child awaken during the night and have trouble returning to sleep?_____
Does your child tend to breathe through their mouth during the day or during sleep? _____
Does your child have dry mouth or bad breath upon waking in the morning? _____

Have you noticed any of the following while your child is sleeping:

- ☐ Snoring
- ☐ Heavy or loud breathing
- ☐ Break or pause in breathing
- ☐ Gasp, choke or struggle to breathe
- ☐ Restless or agitated sleep
- ☐ Grinding teeth
- ☐ Abnormal head posture (hyper-extension, etc.)
- ☐ Excessive sweating
- ☐ Bed wetting

Have you noticed any of the following during the day:

- ☐ Difficulty waking
- ☐ Wakes with headaches
- ☐ Groggy, tired or "out of it"
- ☐ Hyperactive
- ☐ Teacher comments (tired, lack of focus)

Does your child often:

- ☐ Not seem to listen when spoken to directly
- ☐ Have difficulty organizing tasks
- ☐ Become easily distracted by extraneous stimuli
- ☐ Fidget with hands or feet or squirm in seat
- ☐ Interrupt or intrude on others

Please list any questions that you might have for us.

_____
_____
_____

SIGNATURE OF PARENTS OR GUARDIAN: Date:_____

_____ _____
Signature Relationship