SPEECH PEDIATRIC INTAKE

Client Name:	Age: years months		
Parent/Caregiver Name:	DOB:	Sex:	
Address:	City:	State:	Zip:
Phone:	Cell:		

Reason of referral:	
Referral source:	
Pediatrician:	Phone:
Address:	

Health/Medical Issues			
If your child in good health? ☐ Yes ☐ No If not, please describe:			
Does your child have any of the following?	Yes	No	Comments (list dates and results)
History of ear infections	☐	☐	
Myringotomy tubes	☐	☐	
Any Allergies	☐	☐	
Current Medications:			

Please list the date and results of your child's most recent hearing test?

Please list any other important information regarding your child's medical status:

PLEASE COMPLETE ALL PAGES OF THE INTAKE THANK YOU!

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Speech/Language/Developmental Information

Did your child babble as an infant? ☐ Yes ☐ No
If yes, at what age?

At what age does the following occur?	Age	Comments
First word		
Stringing words together to make short sentence		
Sat alone unsupported		
Crawled		
Stood alone		
Fed self with spoon		
Dressed and undressed self		
Describe your child's coordination: ☐ Poor ☐ Average ☐ Good		

About how much of the time can you understand what your child wants when he or she is requesting something: (estimate %)

- The first time ☐%
- After 2 or 3 attempts ☐%
- After many attempts ☐%

About how much of the time can others understand what your child is saying:

- Other immediate family members ____________________
- Familiar relatives or friends ____________________
- Strangers ____________________

What does your child do when trying to communicate? (Check all that apply)

☐ Grunting ☐ Gestures ☐ Drawing ☐ Talking ☐ Other: _______________

What do you do when there is a communication breakdown?

____

____

____

Do you consider your child to understand directions and situation as well as other children of the same age? ☐ Yes ☐ No
If not describe?

____

____

____

Has your child ever had a speech and language evaluation? ☐ **Yes** ☐ **No**
If yes, where?

What were the results?

Does your child have any feeding/swallowing problems? ☐ **Yes** ☐ **No**
If yes, describe?

Did your child fail to gain weight or grow normally? ☐ **Yes** ☐ **No**

What would you like to accomplish from today's speech and language evaluation?

History of Pregnancy, Delivery, Post Delivery	
PREGNANCY: Did you experience any of the following during your pregnancy? Please indicate yes/no.	
Infections ☐ Yes ☐ No	Toxemia ☐ Yes ☐ No
Surgeries ☐ Yes ☐ No	Alcohol consumption during pregnancy ☐ Yes ☐ No
Smoking ☐ Yes ☐ No	Medications ☐ Yes ☐ No
Other:	

DELIVERY: Please answer the questions below:
What was the duration of your pregnancy?
What was your child's birth weight?
Were there complications?
Please check all that apply. Forceps ☐ Cord around neck ☐ Was your baby blue at birth ☐ Hemorrhage ☐ Infant injury during delivery ☐ Anoxia ☐ Was their RH incompatibility ☐
Were there any complications upon delivery?

Post Delivery While in the Hospital

Did your baby have any breathing problems? ☐ Yes ☐ No If yes, please describe:

Please select accordingly	Yes	No	Comments (list dates and results)
Was your baby in an incubator?	☐	☐	Number of days
Did you baby have trouble with sucking	☐	☐	
Where there any complication before going home?	☐	☐	

Additional comments:

____

____

Home/Social/Play Behaviors

All children exhibit, to some changes the kinds of behavior listed below. Check those that your child exhibits to an excessive or exaggerated degree when compared with other children of similar ago. Please select that apply

☐ Hyperactivity	☐ head banging	☐ poor attention span	☐ too many accidents	☐ staring episodes
☐ Impulsivity	☐ sucking Thumb	☐ low frustration threshold	☐ drooling	☐ repetitive movement such as hand waving, rocking, spinning, etc.
☐ temper tantrums	☐ poor memory	☐ sloppy eating habits	☐ eating inedible objects	
☐ destructive	☐ nightmares	☐ does not listen when spoken to	☐ more active than siblings	☐ does not learn from experience
☐ pays no attention to danger	☐ whines frequently	☐ sleeping problems	☐ unusual fears	

What are your child's favorite toys?

____

____

Does your child play with others?

____

Does your child look at other people when they are speaking to him/her?

____

____

Family History			
Mother's Name: ____________________ AGE: ____________________ Address:			
Father's Name: ____________________ AGE: ____________________ Address:			
Siblings	Name	Age	Sex
Does anyone else live in your house? ____________________			
Does anyone in the child's family have developmental delays, speech problems, or special learning problems? ____________________			

Daycare and school History
Day care or school now attending:
Teacher's Name:
Does your child enjoy school?
What is your child's current grade?
Has your child's ever been held back a grade?
Are there problems with the day care or school? ____________________

What feedback have you received about your child's school performance?

____

____

Please list any additional evaluations and results (i.e. physical, occupational or neurodevelopment?)

____

Is there anything else you would like to add regarding your child's overall performance or development?

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