



**SPEECH PEDIATRIC INTAKE**

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

<b>Reason of referral:</b>	
<b>Referral source:</b>	
<b>Pediatrician:</b>	<b>Phone:</b>
<b>Address:</b>	

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

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

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**PLEASE COMPLETE ALL PAGES OF THE INTAKE THANK YOU!**



**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?

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Do you consider your child to understand directions and situation as well as other children of the same age?  Yes  No

If not describe?

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Has your child ever had a speech and language evaluation?  Yes  No

If yes, where?

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What were the results?

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Does your child have any feeding/swallowing problems?  Yes  No

If yes, describe?

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

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

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**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?



<b>Post Delivery While in the Hospital</b>			
Did your baby have any breathing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
<b>Please select accordingly</b>	<b>Yes</b>	<b>No</b>	<b>Comments (list dates and results)</b>
Was your baby in an incubator?	<input type="checkbox"/>	<input type="checkbox"/>	Number of days
Did you baby have trouble with sucking	<input type="checkbox"/>	<input type="checkbox"/>	
Where there any complication before going home?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Additional comments:</b>			
_____			

<b>Home/Social/Play Behaviors</b>				
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				
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> head banging	<input type="checkbox"/> poor attention span	<input type="checkbox"/> too many accidents	<input type="checkbox"/> staring episodes
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> sucking Thumb	<input type="checkbox"/> low frustration threshold	<input type="checkbox"/> drooling	<input type="checkbox"/> repetitive movement such as hand waving, rocking, spinning, etc.
<input type="checkbox"/> temper tantrums	<input type="checkbox"/> poor memory	<input type="checkbox"/> sloppy eating habits	<input type="checkbox"/> eating inedible objects	
<input type="checkbox"/> destructive	<input type="checkbox"/> nightmares	<input type="checkbox"/> does not listen when spoken to	<input type="checkbox"/> more active than siblings	<input type="checkbox"/> does not learn from experience
<input type="checkbox"/> pays no attention to danger	<input type="checkbox"/> whines frequently	<input type="checkbox"/> sleeping problems	<input type="checkbox"/> 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:** \_\_\_\_\_

<b>Siblings</b>	<b>Name</b>	<b>Age</b>	<b>Sex</b>

**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?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_