Pediatric Intake

Child's Name: ___________________________ Date of Birth: _________________ Age: _____

Parent's Name: __________________________ Phone Number: _______________________

Address: ____

Referred By:____

Individuals living in the home: ____

____

Who cares for him/her during the day? ____

Speech and Language Development:

What is your main concern? ____

____

What is your expectation for therapy? ____

____

What language(s) are spoken in the home? ____

____

What is your child's attitude toward the problem? _____________________________________

____

Has your child ever received a speech/language evaluation? (If yes, state date and by whom)

____

____

Has your child ever received speech/language therapy? (If yes, state dates and by whom)

____

____

Is there a family history of speech/language/hearing problems? (If yes, explain) _____________

____

Does your child appear to understand you and follow commands? _________________________

Does your child pronounce words correctly? ____

How does your child communicate? ____

How many words does your child have? ____

Medical History:

Does your child have any of the following medical diagnosis/illnesses? (If yes, mark all that apply)

_____Autism _____ Cerebral Palsy _____ Seizure Disorder

_____Down Syndrome _____ Cleft Palate _____ Asthma

_____ Allergies _____ Meningitis _____ Intrauterine Growth Restriction

_____ Other ____

Where there any difficulties with your pregnancy or child's birth? (If yes, please explain)

____

____

Length of pregnancy: ______________________ Birth weight of child: ____________________

Has your child ever had an ear infection? (If so, how many) ______________________________

Has your child had tubes placed in his/her ears (if so, state the date) ______________________
Has your child had his/her hearing tested? (If so, state the results, date tested, and by whom)
____
Does your child take any medications? (If yes, please state)
____

General Development:
Does your child have difficulty swallowing/chewing food? (If yes, please explain)
____
____
How does your child interact with……
Siblings: ______________________________ Parents:
____
Peers: ______________________________ Other Adults: _____________________________
Give the age at which your child…….
Sat unsupported: _________________________ Spoke first word: _______________________
Crawled: ________________________________ Combined two words: ___________________
Stood up: _______________________________ Walked alone: ___________________________

Educational History:
Present school/daycare: ______________________________ Phone:_____________________
Address: ____
Teacher ____ Grade: _____________________
School Speech/Language Pathologist: ____
Has your child's teacher noted any speech/language problems? (If yes, explain) _____________
____
Does your child have any difficulties with school? (If yes, explain)
____
____
Has your child ever repeated a grade? ____

Please state any additional information that you feel would be helpful for me to know:
____
____
____
____