



Ideal Speech
Orange Park, Florida
oakleafspeech@gmail.com
(904)385-3304

Child Intake Form / History

Client Name: _____ Today's Date _____
 Nickname: _____
 Date of Birth: _____ Age: _____ Male Female
 Diagnosis (if known): _____
 Parent(s) / Guardians: _____
 Address: _____
 City, State, Zip: _____
 Phone #1: _____ Cell Home Work Other
 Phone #2: _____ Cell Home Work Other
 Email #1: _____ Email #2: _____
 Emergency Contact Name: _____
 Emergency Contact Relationship to Child: _____
 Emergency Contact (Information): _____

Client's Physician: _____
 Physician Phone Number: _____
 Physician Address: _____

Other Physicians / Specialists Involved In Care:
 Referring Physician: _____ Phone Number _____
 Physician Address: _____
 Secondary Physician: _____ Phone Number _____
 Physician Address: _____

How did you hear about Ideal Speech?

Family Background

Parent 1 Name: _____ Age: _____
 Occupation: _____ Education Level: _____
 Parent 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____
Marital Status: Single Married Divorced Separated Widowed

What adults does the child live with? Check all that apply:

- Birth Parent(s) Adoptive Parent(s) Foster Parent(s)
Grandparent(s) Both Parents Parent 1 Only
Parent 2 Only Other: _____

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 2 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 3 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 4 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 5 Name: _____ Age: ___ Sex: ___ Speech Issues: _____

Language(s) are spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the language(s): _____

Is there anything additional you would like to share about the family / home environment? _____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____

What are you expecting out of this evaluation / meeting? _____

Has the child had a previous speech, language or feeding evaluation / treatment?

Yes No By whom: _____ When: _____
Describe the results: _____

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: _____

At what age did you first notice the problem? _____

How do the child's communication difficulties impact the family? _____

If anyone else in the family has a speech or language diagnosis, please describe it: _____

Is the child aware of or frustrated by their communication difficulties? _____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? Yes No

Describe: _____

2. Was there any stress during the pregnancy? Yes No

Describe: _____

3. Were there any complications during labor or delivery? Yes No

Describe: _____

4. What was the mother's age at the time of delivery? _____ years

Child's Health:

1. How many weeks gestation was the child born? ___ weeks (40 weeks is typical)

2. The child was _____ lbs _____ oz and _____ inches at birth

3. How was the child delivered? Vaginally Cesarean Section

4. Please describe any complications or concerns during labor or delivery:

Check and describe all that apply:

- Adenoidectomy Describe: _____
- Asthma Describe: _____
- Behavior Issues Describe: _____
- Brain injury Describe: _____
- Breathing problems Describe: _____
- Cardiac issues Describe: _____
- Chicken pox Describe: _____
- Diabetes Describe: _____
- Ear infections Describe: _____
- Ear tubes Describe: _____
- Encephalitis Describe: _____
- Frequent colds Describe: _____
- High fever Describe: _____
- Measles Describe: _____
- Meningitis Describe: _____
- Mumps Describe: _____
- Seizures Describe: _____
- Sensory issues Describe: _____
- Sleep issues Describe: _____
- Tongue tie Describe: _____
- Tonsillitis Describe: _____
- Tonsillectomy Describe: _____
- Traumatic brain injury Describe: _____
- Vision issues Describe: _____

Is the child up to date with immunizations: Yes No

Please describe: _____

Has the child ever had surgery? Yes No

Please describe: _____

Has the child ever been hospitalized: Yes No

Please describe: _____

Has the child ever been in a serious accident? Yes No
Please describe: _____

Does the child have a chronic illness? If so, please describe: _____

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Does the child have any known allergies? Yes No
Describe: _____

Does the child currently use any equipment? (communication device, walker, etc.) Describe: _____

Does the child have a history of ear infections, tubes, etc. or use hearing aides?
 Yes No
Describe: _____

Does the child have any known hearing loss? Yes No
Describe: _____

If you have any concerns about the child's hearing, please describe: _____

Describe the child's current health status: _____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

- Developmental Pediatrician _____
- Neurologist _____
- PT _____
- OT _____
- SLP _____
- Behavioral Therapist _____
- Educational Consultant _____
- Psychologist / Psychologist _____
- Vision Therapist _____
- Other: _____

Developmental History

At what age did the child do the following:

- | | |
|-----------------------|----------------------------|
| Sit alone: _____ | Crawl: _____ |
| Stood Up: _____ | Walk: _____ |
| Made Sounds: _____ | First Word: _____ |
| Combined Words: _____ | Sentences: _____ |
| Fed Self: _____ | Understood by Others _____ |
| Toilet Trained: _____ | Dressed Self: _____ |

Does the child do any of the following:

- Choke on liquids Choke on foods
 - Avoid foods Maintain a special diet
 - Use a pacifier / suck thumb Mouth objects
- Please describe any of the above: _____

If under 4 years of age, how many words does the child say:

- 0-20 21-50 51-100 101-150 151-300 301-500 501+

Does the child produce sentences of the following length:

- 2 words 3 words 4 words 5+ words

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____

Does the child have any difficulty with the following:

- | | |
|---|--|
| <input type="checkbox"/> Attention | <input type="checkbox"/> Frustration Tolerance |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Answering simple questions | <input type="checkbox"/> Answering –wh questions |
| <input type="checkbox"/> Understanding people | <input type="checkbox"/> Following directions |
| <input type="checkbox"/> Excessive drooling | <input type="checkbox"/> Chewing or eating |
| <input type="checkbox"/> Producing speech sounds | <input type="checkbox"/> Stuttering |
| <input type="checkbox"/> Reading | <input type="checkbox"/> School work |
| <input type="checkbox"/> Remembering | <input type="checkbox"/> Maintaining eye contact |
| <input type="checkbox"/> Transitions | <input type="checkbox"/> Word Retrieval |

Other difficulties: _____

Please describe any of the above: _____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____

Educational History

Is the child currently enrolled in daycare/ school: Yes No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe: _____

Please describe any educational difficulties or learning challenges that this child has faced: _____

Social History

Describe how the child interacts with parents, siblings, or other family members:

Please describe the communication difficulties the child faces in the home environment: _____

Describe any significant events or changes within the home: _____

What are the child's strengths? _____

What are the child's weaknesses? _____

What are the child's favorite activities? _____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____

Does the child become easily frustrated with certain activities? If so, please explain: _____

Describe how the child interacts with other children: _____

What are your goals for the child over the next 6 months? _____

What are your goals for the child over the next 5 years? _____

Is there anything else that is important for us to know about the child?

Person filling out the form: _____
Relationship to the child: _____

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