

Child Intake Form

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST **BEFORE** YOUR CHILD'S FIRST THERAPY SESSION.

CHILD'S INFORMATION			
FULL NAME		GENDER	DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE	
INSURANCE COMPANY		INS NUMBER	
DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs.			
How does your child react to being misunderstood or unable to communicate?			
Why are you seeking speech-language services for your child?			
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?			
How did you learn about us?			
In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. <input type="checkbox"/> None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	<input type="checkbox"/> Biological parent(s)	<input type="checkbox"/> Adoptive parent(s)	<input type="checkbox"/> Legal guardian(s)
	<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Other:
In the table to the right, list all family members who live in the same home as your child.	NAME	AGE	RELATION TO CHILD
Do you have any family pets? (List name and type)			
PARENT 1 INFORMATION			
FULL NAME	GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
ADDRESS	CITY	ZIP	
PHONE 1	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	EMAIL	
PHONE 2	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	PREFERRED METHOD OF CONTACT	<input type="checkbox"/> PHONE 1 <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE 2
PLACE OF EMPLOYMENT	POSITION		
PARENT 2 INFORMATION			
FULL NAME	GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
ADDRESS	CITY	ZIP	
PHONE 1	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	EMAIL	
PHONE 2	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	PREFERRED METHOD OF CONTACT	<input type="checkbox"/> PHONE 1 <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE 2
PLACE OF EMPLOYMENT	POSITION		
Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)			
Are there any other languages spoken in the home? If yes, which language(s) and how often?			
Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER	
CHILD'S HEALTH BACKGROUND			

Describe your pregnancy, including any complications.			
Describe your labor/delivery, including any complications.			
TYPE OF BIRTH (check all that apply) <input type="checkbox"/> Spontaneous (not induced) <input type="checkbox"/> Induced <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section			
BIRTH PLACE (hospital/birth center)		BIRTH ATTENDANT (physician, midwife)	
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	NICU <input type="checkbox"/> Yes <input type="checkbox"/> No How long?
Were there any complications after birth or during the first few weeks?	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty feeding <input type="checkbox"/> Birth defect <input type="checkbox"/> Jaundice <input type="checkbox"/> Seizures <input type="checkbox"/> Other:		
Has your child's hearing been tested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where?			<input type="checkbox"/> Passed <input type="checkbox"/> Did not pass
Describe any serious illnesses, injuries, or medical procedures your child has experienced.			
List any environmental or food allergies.			
List any routine medications your child is currently taking or has taken long term.			
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.			

CHILD'S FEEDING DEVELOPMENT		
BREASTFED from _____ months until _____ months	FORMULA FED from _____ months until _____ months	BOTTLE until _____

At what age did your child begin using the following?	<input type="checkbox"/> SIPPY CUP _____ months <input type="checkbox"/> STRAW _____ months <input type="checkbox"/> OPEN CUP _____ months <input type="checkbox"/> UTENSILS _____ months
Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc.	
FAVORITE FOODS	FOOD AVERSIONS

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT

At what age did your child begin:	<input type="checkbox"/> BABBLING (bababa) _____ months <input type="checkbox"/> JARGON (bada bama) _____ months <input type="checkbox"/> FIRST WORD _____ at _____ months <input type="checkbox"/> TWO-WORD COMBO (more milk) _____ months <input type="checkbox"/> THREE-WORD COMBO _____ months/years <input type="checkbox"/> SENTENCES _____ months/years <input type="checkbox"/> READING LETTERS _____ years <input type="checkbox"/> WRITING LETTERS _____ years <input type="checkbox"/> READING WORDS _____ years <input type="checkbox"/> WRITING WORDS _____ years <input type="checkbox"/> READING SENTENCES _____ years <input type="checkbox"/> WRITING SENTENCES _____ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	<input type="checkbox"/> Parent(s) <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Peers <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Extended Family <input type="checkbox"/> Strangers _____ % _____ % _____ % _____ % _____ % _____ %
Has your child's speech-language been evaluated before? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

CHILD'S STRENGTHS AND FAVORITES

Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE TOYS	
FAVORITE MOVIES	
FAVORITE BOOKS	

Thank you for taking the time to complete this case history form. The information you have provided is crucial and helps us gain a better understanding of who your child is. Any information provided is kept strictly confidential and will not be shared with any other parties without your written consent. **By signing this page, you consent for UpWords Speech Therapy Services, LLC to evaluate your child.**

PARENT/GUARDIAN SIGNATURE

DATE