DISCOVERING EXPRESSION
SPEECH & LANGUAGE

SPEECH AND LANGUAGE INTAKE FORM

Date: _____

Patient Information (Child)

First Name:_____
Last Name:_____
Date of Birth:_____ Phone:_____
Address: _____
City/State:_____ Zip :_____
Pediatrician/Physician Name: _____
Pediatrician/Physician Phone: _____
Primary language: _____ Secondary language:_____

Parent/Guardian Information

Parent/Guardian A	Parent/Guardian B
Name: _____	Name: _____
Phone: _____	Phone: _____
Relationship to child: _____	Relationship to child: _____
Resides with child:	Resides with child:
___ Full-time ___ Part-time	___ Full-time ___ Part-time
___Other:	___Other:
Profession/Employer: _____	Profession/Employer: _____
_____	_____

Family/Social History

Do any immediate or extended family members have a history of:

Language Disorders? ___ Yes ___ No
Learning Disabilities? ___ Yes ___ No
Motor Disorders? ___ Yes ___ No
Articulation Disorders? ___ Yes ___ No
Stuttering? ___ Yes ___ No
Apraxia of Speech? ___ Yes ___ No

If YES to any of the above or a family history of any learning/developmental difficulties, please describe: _____
_____
_____
_____

Please describe the child's living situation, including the names and ages of everyone living in the household:

_____
_____
_____
_____

Does your child currently attend school, preschool, or daycare? ___ Yes ___ No
If yes, where and for how long?_____
_____

Current Concerns

Please check all that apply:
___ Articulation (the way my child makes sounds)
___ Expressive language (the way my child uses words)
___ Receptive language (the way my child understands words)
___ Pragmatics (my child's social abilities)
___ Fluency (my child has a stutter or "bumpy speech")
___ Hearing
___ Feeding/Swallowing
___ Self-help skills
___ Vision
___ Fine motor and/or gross motor skills
___ Emotional regulation and adjustment abilities (how child handles feelings and transitions)
___ Sensory processing

Please briefly describe your concerns:

_____
_____
_____

When did you first notice these concerns?

_____
_____

How does your child communicate? Check all that apply.

___ Babbling/sounds	___ Gestures/pointing	___ Sign language
___ Single words	___ Two-word phrases	___ 3-4 word phrases
___ Sentences with Errors	___ Full sentences	___ Tells stories/explains events

___ Other (please describe): _____
_____

Does your child use a speech generating device or picture communication system? __Yes __No
If yes, what program/system?_____
How long have they been using it? _____

Approximately how many words does your child say? _____

How long are your child's sentences? _____

What percentage of your child's speech do you understand?
___ <25% ___ 25-50% ___ 50-75% ___ 75-90% ___ >90%

What percentage of your child's speech do unfamiliar listeners understand?
___ <25% ___ 25-50% ___ 50-75% ___ 75-90% ___ >90%

When did your child say their first word? _____

Medical History

HEARING STATUS

Does your child have a history of ear infection or middle ear fluid? ___ Yes ___ No
If yes, did your child have Ear Tubes placed? ___ Yes ___ No
When/Where were tubes placed?_____

When was the date of your child's last hearing screening/assessment? _____
Provider/location: _____
What was the result? ___ Normal ___ Abnormal: _____

FEEDING HISTORY

Did your child have any difficulty with feeding (e.g., choking with liquids, difficulty managing solids, trouble transitioning to textures, poor weight gain, reflux, etc.)? ___ Yes ___ No
If yes, describe: _____
_____

MEDICAL INFORMATION

Please list any current diagnoses your child has, and when/where it was received:
_____
_____
_____

Please list any significant illnesses or surgeries since birth: _____
_____
_____

Please list any and all interventions your child has previously or is currently receiving (occupational therapy, physical therapy, speech therapy, ABA, counseling, etc.), including dates and location (including services provided through the school district on an IEP):
_____
_____
_____
_____

Were there any complications during pregnancy or delivery? ___ Yes ___ No
If yes, please describe: _____
_____
_____
_____

Previous Evaluations

Please list below what types of evaluations the child has had (e.g., speech and language, early intervention, developmental assessments, reading, neuropsychological, etc.):		
Type of Evaluation	Where	Date
Please send in/bring copies of relevant evaluation reports		

Getting To Know Your Child

Likes: _____
_____

Dislikes: _____
_____

Is there any other information you think is relevant to this assessment, or that you would like your provider to know?
_____
_____
_____
_____
_____
_____