Client Intake Form

Patient Information

Date: _____

Patient Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Parents/Guardians: _____

Relationship to Patient: _____

Street Address: _____

City, State, Zip: _____

Daytime Phone: _____

Mobile Phone: _____

Alternate Phone: _____

Email Address: _____

Alternative Email Address: _____

Best Method of Contact: ☐ Email ☐ Phone Best Time of Day: _____

Does you child have any allergies? ☐ Yes ☐ No

If yes, please explain: _____

Please list any family members or friends that are influential to your child:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the problems with which you want help for your child:

_____

_____

_____

Client Intake Form

How would you describe your child's biggest challenge at home/school:

_____
_____
_____
_____
_____
_____

Does your child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No
If Yes, what is the primary focus of the plan?

_____
_____

Child's School Name: _____

Providing copies of the current IEP, previous academic, speech/language evaluations or medical reports support development of a thorough treatment plan.

FINANCIAL RESPONSIBILITY: I understand that I am ultimately financially responsible for all charges provided for therapeutic, evaluation and consultation services.
Signature: _____ Date: _____
Name (printed):_____

CONFIDENTIALITY AGREEMENT/CONSENT for EXCHANGE OF INFORMATION:
All information provided will remain confidential. Written consent is necessary to discuss patient information.
I hereby authorize _____ to contact, discuss findings and progress, and release medical information to the following professionals as related to evaluation and treatment of the patient.

Please provide contact information.
____ Spouse or Family Member _____
____ Teachers _____
____ Specialists (i.e. ENT, Dentists, Psychologists) _____
____ Therapist _____

Signature: _____ Date: _____

Client Intake Form

MEDICAL INFORMATION TRANSMISSION: Medical information is provided to parents upon request. Medical information include patient name, date upon of birth, visit number/referrals if applicable, a brief summary of therapeutic services as well as recommendations for home practice if appropriate. In the interest of time efficiency, information may be sent to parent/guardian via email.

I consent to the electronic submission of patient session notes.
Signature: _____ Date: _____

Medical History
Number of week's gestation:_____
Age during pregnancy:_____
Type of delivery:_____

Please list any injuries, specific illnesses, or other medical complications diagnosed during pregnancy:
_____
_____

Were there any complications during labor and delivery by mother?
_____
_____

Were there any complications during labor and delivery by baby?
_____
_____

Were there any problems experienced by baby immediately following the birth?
_____
_____

If so, what were the causes and treatments?
_____
_____
_____

Please list any previous and/or present illnesses, surgeries, injuries, and treatment(s):
_____
_____
_____

Client Intake Form

Is your child currently taking any medication(s)? If so, please list them:

_____

_____

Ear infections/course of treatment(s):_____

Developmental History

At what age did your child demonstrate the following skills:

Roll over:_____ Sit without support:_____ Crawl:_____ Walk:_____

Babbled:_____ First Real words: _____

Feeding

Has the child breast or bottle fed?_____

Age weaned:_____

Early difficulties with gagging, choking, chewing difficulties or swallowing? ☐ Yes ☐ No

Explain:_____

Any present difficulties with same? ☐ Yes ☐ No

Explain:_____

When were solid foods introduced?_____

Does the child have preference or avoidance of any particular food types, textures, temperature, or tastes?

_____

_____

_____

Any difficulties with spoon_____ fork_____ cup_____ knife_____

Speech Language History

How would you describe your child's communication?

_____

_____

_____

Does your child…

Frequently hesitate or repeat sounds, words or phrases? ☐ Yes ☐ No

Understand what you are saying? ☐ Yes ☐ No

Retrieve common items upon request? ☐ Yes ☐ No

Client Intake Form

Does your child…

Follow simple directions? ☐ Yes ☐ No

Correctly answer who, what, where, when, why questions? ☐ Yes ☐ No

List any errors in speech production that you have observed:_____

_____

Does your child have a hearing loss? ☐ Yes ☐ No

Has your child experienced laryngitis? ☐ Yes ☐ No

If so, when and how frequently? _____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

Does the child _____speak and/or _____ understand the language?

Which language does the child prefer to speak at home? _____

Is dentition normal? ☐ Yes ☐ No

If No, Explain _____

_____

Does your child have difficulty with attention? ☐ Yes ☐ No

If Yes, Explain _____

Is your child aware of or frustrated by speech/language difficulties? ☐ Yes ☐ No

If Yes, Explain _____

How does the child make his/her needs/wants known? _____

_____

Socialization/Play Behaviors/Interests

Is the child able to separate from primary caregiver?_____

How does the child get along with caregivers?_____

How does the child get along with other children?_____

How does the child respond to new situations, people and places? _____

Describe child's reaction to discipline:_____

Tantrums/Agression?_____

Does your child demonstrate any self-stimulatory behaviors?_____

Describe child's play with toys, peers, and adults:_____

Does the child have any perseverative/ritualistic behaviors?_____

Please list the child's favorite toys and activities:_____

Does your child take turns and share toys with others?_____

Does your child enjoy playing with other children?_____

Client Intake Form

General

Has your child undergone a screening? ☐ Yes ☐ No

If so, where/when? _____

Has your child received therapy in the past? ☐ Yes ☐ No

If so, where/when? _____

What was the focus of therapy?_____

_____

_____

Are there academic concerns? ☐ Yes ☐ No

If Yes, Please describe _____

Please add any information which you feel may help us to better understand your child:

_____

_____

_____

_____

_____

_____