Logoped LLC

Speech and Language Evaluation and Therapy Intake Form

Please fill out all information you think appropriate and comfortable for you to disclose. It will be kept confidential at all times.

General Information

Name: _____ Date of Birth: _____

Address: _____ City: _____

Zip Code: _____

Phone (cell): (_____) _____ - _____

Does the child live with both parents: Yes_____ No _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____

Business phone (if applicable): (_____) _____ - _____

Personal cell: (_____) _____ - _____

Father's Name: _____ Age: _____

Father's Occupation: _____

Business phone (if applicable): (_____) _____ - _____

Personal cell: (_____) _____ - _____

Referred by: _____ Phone: (_____) _____ - _____

Pediatrician: _____ Phone: (_____) _____ - _____

Family Doctor: _____ Phone: (_____) _____ - _____

1. Patient's Siblings (please include names and ages):

_____

_____

2. What languages does the child speak? What is the child's dominant language?

_____

_____

3. What languages are spoken at home? What is the dominant language spoken?

_____

_____

4. With whom does the child spend most of his/her time?

_____

5. Describe the child's speech-language problem.

_____

_____

_____

6. How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____

_____

_____

7. When was the problem first noticed and by whom?

_____

_____

8. List any factors you think may have caused the problem.

_____

_____

_____

9. Has the problem changed since it was first noticed?

_____

_____

10. Is the child aware of the problem? If yes, how does he or she feel about it?

_____

_____

_____

11. Have any other speech-language specialists seen the child? What were their conclusions or suggestions?

_____

_____

_____

12. Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

_____

_____

_____

13. Are there any other speech, language, or hearing problems in the family?

_____

_____

Prenatal and Birth History (mother's general health during pregnancy (illnesses, accidents, medications, etc.)

Length of pregnancy: _____ Length of labor: _____

General condition: _____

Birth weight: _____

Type of delivery:

- Head first
- Assisted delivery
- Breech/Feet first
- Caesarian

1. Were there any unusual conditions that may have affected the pregnancy or birth?

_____

_____

_____

Medical History

Provide the approximate ages at which the child experienced the following illness and conditions if applicable:

- Asthma _____
- Croup _____
- Ear infection _____
- Headaches _____
- Mastoiditis _____
- Mumps _____
- Sinusitis _____
- Chicken pox _____
- Dizziness _____
- Encephalitis _____
- High fever _____
- Measles _____
- Pneumonia _____
- Tinnitus _____
- Colds _____
- Draining ear _____
- German measles _____
- Influenza _____
- Meningitis _____
- Seizures _____
- Tonsillitis _____
- Other _____

1. Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, tube placement)?

_____

_____

_____

2. Describe any major accidents or hospitalizations.

_____

_____

_____

3. Is the child taking any medications? Have there been any negative reactions to medications?

_____

_____

_____

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl _____ Sit_____ Stand_____ Walk_____

Feed Self_____ Dress self_____ Use toilet_____

Use single words (e.g., no, mom, doggie)_____

Combine words (e.g., me go, daddy shoe)_____

Name simple objects (e.g., dog, car, tree)_____

Use simple questions (e.g., Where's doggie?)_____

Engage in conversation _____

1. Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

_____

_____

2. Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

_____

_____

_____

3. Describe the child's response to sounds (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

_____

_____

_____

Educational History

School: _____ Grade: _____

Teacher(s): _____

1. How is the child doing academically (or pre-academically)?

_____

_____

_____

2. Does the child receive special services? If yes, describe.

_____

_____

_____

3. How does the child interact with others (e.g., shy, aggressive, uncooperative)?

_____

_____

4. If enrolled for special education services, has an Individual Educational Plan (IEP) been developed? If yes, describe the most important goals.

_____

_____

_____

Person completing form: _____

Relationship to client: _____

Signature: _____ Date: _____