Laura S. Smith, MS, CCC-SLP, COM™
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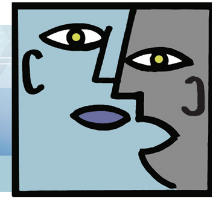
Tongue thrust, articulation, language and /k/ommunication



Talk SLP LLC

CHILD INTAKE FORM

OFFICE USE ONLY	
ID	
DATE	
OTHER	

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 AT YOUR EARLIEST CONVENIENCE.

CHILD'S INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
CURRENT AGE	NAME OF SCHOOL	GRADE
PRIMARY CARE PHYSICIAN (PCP)	PCP PHONE	

DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and where the problem occurs.	
How does your child react to being misunderstood or unable to communicate?	☐ Tries again/revises ☐ Becomes angry/frustrated ☐Other: ☐ Gives up ☐ Doesn't notice
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. ☐ None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	☐ Biological parent(s) ☐ Grandparent(s)	☐ Adoptive parent(s) ☐ Sibling(s)	☐ Legal guardian(s) ☐ 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 ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
PLACE OF EMPLOYMENT	POSITION	

PARENT 2 INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ 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)	☐ Spontaneous (not induced) ☐ Induced ☐ Vaginal ☐ C-section
BIRTH PLACE (hospital/birth center)	BIRTH ATTENDANT (physician, midwife)
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT
BIRTH LENGTH	NICU ☐ Yes ☐ No How long?
Were there any complications after birth or during the first few weeks?	☐ Difficulty breathing ☐ Difficulty feeding ☐ Birth defect ☐ Jaundice ☐ Seizures ☐ Other:
Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and where?	☐ Passed ☐ 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?	☐ SIPPY CUP ________ months ☐ STRAW ________ months ☐ OPEN CUP ________ months ☐ 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: (YOUR BEST ESTIMATE)	☐ BABBLING (bababa) _______ months ☐ JARGON (bada bama) _______ months ☐ FIRST WORD__________ at _______ months ☐ TWO-WORD COMBO (more milk) _______ months ☐ THREE-WORD COMBO _______ months/yrs ☐ SENTENCES _______ months/years ☐ READING LETTERS _______ years ☐ WRITING LETTERS _______ years ☐ READING WORDS _______ years ☐ WRITING WORDS _______ years ☐ READING SENTENCES _______ years ☐ WRITING SENTENCES _______ years * USED PACIFIER FROM ______ to ______ mos. * SUCKED THUMB/FINGER FROM ______ to ______ mos.
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	☐ Parent(s) ______% ☐ Sibling(s) ______% ☐ Peers ______% ☐ Teacher(s) ______% ☐ Extended Family ______% ☐ 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 information about your child.

_______________________________________ _________________________

PARENT/GUARDIAN SIGNATURE DATE