ALIGN
SPEECH THERAPY AND CONSULTING

Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ ☐Male ☐Female

Diagnosis (if known): _____

Parent(s) / Guardians: _____

Address: _____

City, State, Zip: _____

Phone #1:_____ ☐Cell ☐Home ☐Work ☐Other

Phone #2:_____ ☐Cell ☐Home ☐Work ☐Other

Email #1:_____ Email #2: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

How did you hear about Align Speech Therapy and Consulting?

_____

Family Background

Parent 1 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Parent 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

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What adults does the child live with? Check all that apply:
☐ Birth Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s)
☐ Grandparent(s) ☐ Both Parents ☐ Parent 1 Only
☐ Parent 2 Only ☐ Other:
_____

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____Age: __ Sex: __ Speech Issues:_____
Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 3 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 4 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 5 Name: _____ Age: __ Sex: __ Speech Issues:_____

Language(s) spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the language(s): _____
_____

Is there anything additional you would like to share about the family / home environment? _____
_____
_____

Evaluation
Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____
_____
_____
_____

What are you expecting out of this evaluation / meeting? _____
_____
_____

Has the child had a previous speech, language or feeding evaluation / treatment?
☐ Yes ☐ No By whom: _____When: _____
Describe the results: _____
_____

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Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: _____
_____
_____
_____
_____

At what age did you first notice the problem? _____

How do the child's communication difficulties impact the family? _____
_____
_____

If anyone else in the family has a speech or language diagnosis, please describe it: _____
_____
_____

Is the child aware of or frustrated by their communication difficulties? ____
_____
_____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____
_____
_____
_____
_____
_____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No
Describe: _____
2. Was there any stress during the pregnancy? ☐Yes ☐No
Describe: _____
3. Were there any complications during labor or delivery? ☐Yes ☐No
Describe: _____

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4. What was the mother's age at the time of delivery? ____ years

Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? ☐Vaginally ☐Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

_____
_____
_____

Check and describe all that apply:

☐Adenoidectomy Describe: _____
☐Asthma Describe: _____
☐Behavior Issues Describe: _____
☐Brain injury Describe: _____
☐Breathing problems Describe: _____
☐Cardiac issues Describe: _____
☐Chicken pox Describe: _____
☐Diabetes Describe: _____
☐Ear infections Describe: _____
☐Ear tubes Describe: _____
☐Encephalitis Describe: _____
☐Frequent colds Describe: _____
☐High fever Describe: _____
☐Measles Describe: _____
☐Meningitis Describe: _____
☐Mumps Describe: _____
☐Seizures Describe: _____
☐Sensory issues Describe: _____
☐Sleep issues Describe: _____
☐Tongue tie Describe: _____
☐Tonsillitis Describe: _____
☐Tonsillectomy Describe:_____
☐Traumatic brain injury Describe: _____
☐Vision issues Describe: _____

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Is the child up to date with immunizations: ☐Yes ☐No
Please describe: _____
_____
_____

Has the child ever had surgery? ☐Yes ☐No
Please describe: _____
_____
_____

Has the child ever been hospitalized: ☐Yes ☐No
Please describe: _____
_____
_____

Has the child ever been in a serious accident? ☐Yes ☐No
Please describe: _____
_____
_____

Does the child have a chronic illness? If so, please describe: _____
_____
_____

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Does the child have any known allergies? ☐Yes ☐No
Describe: _____
_____
_____

Does the child currently use any equipment? (communication device, walker, etc.) Describe: _____
_____

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Does the child have a history of ear infections, tubes, etc. or use hearing aides?
☐Yes ☐No
Describe: _____
_____
_____

Does the child have any known hearing loss? ☐Yes ☐No
Describe: _____
_____
_____

If you have any concerns about the child's hearing, please describe: _____
_____
_____

Describe the child's current health status: _____
_____
_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.
☐Developmental Pediatrician _____
☐Neurologist _____
☐PT _____
☐OT _____
☐SLP _____
☐Behavioral Therapist _____
☐Educational Consultant _____
☐Psychologist / Psychiatrist _____
☐Vision Therapist _____
☐Other: _____

Developmental History
At what age did the child do the following:
Sit alone: _____ Crawl: _____
Stood Up: _____ Walk: _____
Made Sounds: _____ First Word: _____
Combined Words: _____ Sentences: _____

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Fed Self: _____ Understood by Others_____
Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:

☐Choke on liquids ☐Choke on foods
☐Avoid foods ☐Maintain a special diet
☐Use a pacifier / suck thumb ☐Mouth objects
Please describe any of the above: _____
_____
_____

If under 4 years of age, how many words does the child say:
☐0-20 ☐21-50 ☐51-10 ☐101-150 ☐151-300 ☐301-500 ☐501+

Does the child produce sentences of the following length:
☐2 words ☐3 words ☐4 words ☐5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____
_____
_____

Does the child have any difficulty with the following:

☐Attention ☐Frustration Tolerance
☐Aggression ☐Anger
☐Answering simple questions ☐Answering –wh questions
☐Understanding people ☐Following directions
☐Excessive drooling ☐Chewing or eating
☐Producing speech sounds ☐Stuttering
☐Reading ☐School work
☐Remembering ☐Maintaining eye contact
☐Transitions ☐Word Retrieval
☐Other difficulties: _____
Please describe any of the above: _____
_____

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Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____
_____
_____

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe: _____
_____
_____

Please describe any educational difficulties or learning challenges that this child has faced: _____
_____
_____
_____

Social History

Describe how the child interacts with parents, siblings, or other family members:
_____
_____
_____

Please describe the communication difficulties the child faces in the home environment: _____
_____
_____
_____

Describe any significant events or changes within the home: _____
_____

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What are the child's strengths? _____
_____
_____
_____

What are the child's weaknesses? _____
_____
_____
_____

What are the child's favorite activities? _____
_____
_____
_____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____
_____
_____

Does the child become easily frustrated with certain activities? If so, please explain: _____
_____
_____

Describe how the child interacts with other children: _____
_____
_____

What are your goals for the child over the next 6 months? _____
_____
_____
_____

What are your goals for the child over the next 5 years? _____
_____
_____
_____

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Is there anything else that is important for us to know about the child?

_____
_____
_____
_____
_____
_____

Person filling out the form: _____
Relationship to the child: _____