Total Pediatric Therapy Speech and Language Intake

Patient Name _____ Date _____

Was your child born full term? ☐ Yes ☐ No If no, what gestational age? _____

Did your child require any advanced medical care upon birth? ☐ Yes ☐ No

Were there any problems during pregnancy? ☐ Yes ☐ No

If you answered yes to any of the above questions, please describe:

_____

_____

_____

Home Environment:

Who lives at home with the child? (Siblings (ages), mother, father, step-parents, grandparents, etc):

_____

How often is English spoken at home? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Never

If another language is spoken, what language(s) is/are used in the home?_____

Any special home circumstances?_____

Parents relationship: ☐ Married ☐ Divorced ☐ Joint physical custody ☐ Child Adopted ☐ Other_____

Any cultural or religious considerations for therapy? (holiday celebrations, prohibitions, etc) _____

_____

Health History:

Please Mark Appropriate Box(es) If Your Child Has Had Any of The Following:

- ☐ Frequent Ear Infections
- ☐ Early Intervention
- ☐ Speech Therapy
- ☐ Allergies (list below)
- ☐ Hearing Problems
- ☐ Occupational Therapy
- ☐ Tubes in Ears
- ☐ Physical Therapy
- ☐ Head Injury
- ☐ Developmental Delay
- ☐ Behavior Therapy
- ☐ Premature Birth
- ☐ Hospitalization

Please provide further explanations for items checked above:

_____

List current medications: _____

Is your child diagnosed with any Developmental or Sensory Disorders?

- ☐ Language Disorder
- ☐ Social Communication Disorder
- ☐ Dyslexia
- ☐ Articulation Disorder
- ☐ Stuttering
- ☐ Sensory Processing Disorder
- ☐ ADHD
- ☐ Anxiety
- ☐ Autism
- ☐ Intellectual Disability
- ☐ Fragile X Syndrome
- ☐ Degenerative Condition
- ☐ Blind
- ☐ Deaf/Hard of Hearing
- ☐ Cerebral Palsy
- ☐ Down's Syndrome
- ☐ Learning Disorder
- ☐ Other (list below)

Please provide further explanations for items checked above:

_____

_____

Do you suspect your child has any undiagnosed disorders? ☐ Yes ☐ No

If yes, explain:

_____

_____

Education:

How Is Your Child Currently Educated?: ☐Distance Learning ☐Pre-school/school ☐Homeschool

What is your child's current grade level? _____

Has Your Child Ever Been Held Back a Grade? ☐Yes ☐No

Which Subjects in School is Your Child on Grade Level for? ☐ Reading ☐Math ☐Science ☐ Social Studies

Does Your Child Receive Special Education Services? ☐Yes ☐No

Does Your Child Have an IEP or IFSP? ☐Yes ☐No

If yes, what is it targeting?

_____

_____

Communication:

When/where was their most recent hearing test? _____

Vision test? _____

Did your child have difficulties with feeding after birth?

Breast: ☐Yes ☐ No Bottle: ☐ Yes ☐ No

If yes, please explain:

_____

Does your child currently have any swallowing difficulties/excessive coughing or choking when eating or drinking?

☐ Yes ☐No

If yes, please explain:

_____

Which of the following areas of communication do you feel your child may need speech therapy to improve? (check all that apply)

☐Understanding Language ☐Expressing Language ☐Speech sounds

☐Fluency/Stuttering ☐Social communication ☐Voice

When did you first become concerned?

_____

Follow simple (check all that appply): ☐1-step directions ☐2-step directions ☐3-step directions

Point to/go to/reach for/ or otherwise identify people and objects you name? ☐Yes ☐No

Point to basic body parts you name? ☐Yes ☐No

Answer simple yes/no questions accurately? ☐Yes ☐No

Answer simple "wh" questions accurately? (what, where, who, when, why, how) ☐Yes ☐No

Which of the following describes how your child communicates: (check all that apply)

☐Pointing
☐Eye Contact
☐Communication Boards
☐Sign Language
☐Communication Device (what kind)
☐Symbols (gives items/symbols to communicate)

☐Gesturing
☐Facial Expressions
☐Pulls Person
☐Objects
☐Pictures
☐Writing

☐Vocalizing
☐Single Words
☐Two-Word phrases
☐3-4 word utterances
☐Babbling
☐Full Sentences
☐Other (please explain)

Please provide further explanations for items checked above:

_____

_____

Does your child communicate (verbally or non-verbally) to: (check all that apply)

☐Ask for wants/needs
☐Greet people
☐Label people, things, or pictures around them?

☐Ask questions
☐Ask for help
☐Get your attention
☐Share information

Intelligibility:

If your child speaks:

Do you have difficulty understanding his/her speech? ☐ Yes ☐ No ☐ Sometimes

How much of what he/she says do you understand?

☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75% - 100%

Do others have difficulties understanding his/her speech? ☐ Yes ☐ No ☐ Sometimes

How much of what he/she says do you think others understand?

☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75% - 100%

What does your child do when they are not understood? Please explain. (repeats or modifies message, gives up, becomes aggressive, etc.)

_____

_____

Family/Caregiver Goals:

What do you hope to gain from this evaluation?

_____

_____

What is the main goal you wish to accomplish with speech therapy?

_____

_____

_____ _____

Patient or Personal Representative Signature **Date**