



**Pediatric Speech and Language Intake Form**

Contact Information:

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preferred mode of contact: [ ] phone [ ] e-mail

**Caregivers:**

Relationship to child: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Siblings: (Please include age/grade level)

\_\_\_\_\_

Language(s) spoken in the home:

\_\_\_\_\_

\*What are your major concerns at this time?

\_\_\_\_\_

\*Have you consulted any other professionals regarding these concerns?

\_\_\_\_\_

Please describe your child's communication (babbling, gestures, single words, phrases, sentences, conversation)

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Is your child difficult to understand? If so, are there particular sounds that are challenging?

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Is your child aware of his or her problem? If so, how does he or she handle it?

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Is there any history of speech, language or learning challenges in your family?

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Prenatal and Birth History:

Length of pregnancy: \_\_\_\_\_ Length of labor: \_\_\_\_\_

C-section: Yes / No Birth Weight: \_\_\_\_\_

Please note any unusual conditions that may have affected prenatal development, including mother's general health during pregnancy.

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Medical History:

[ ] Chronic colds/respiratory infections [ ] Chronic ear infections

[ ] Asthma [ ] Allergies [ ] High fever [ ] Influenza

Is your child taking any medications? If so, please describe duration and frequency.

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Has your child been hospitalized? Has your child had any surgery?

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Additional health information:

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Developmental History:

Please provide the approximate age at which your child began the following activities:

Crawl		Sit	
Stand		Walk	
Self-feed		Dress self	
Point		Babble	
Use single words		Name objects	
Use phrases		Use toilet	

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

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Does your child have any negative reactions to sensory stimuli (i.e., noise, light, tastes, smells, touch)?

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Describe your child's response to sound (e.g., responds to all sounds, tolerates loud noises, inconsistently responds to sounds, etc.)

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Does/Did your child ever use a pacifier/suck thumb or have an attachment to any other objects they put in their mouth? Yes / No

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Are there or have there been any feeding or eating problems (e.g., any problems with sucking, tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe.

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From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle)

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Describe your child's attention level. Can your child occupy him or herself independently?

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Does your child follow simple directions? Do you have concerns about your child's ability to understand what is being said to him/her?

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What motivates your child most? (favorite toys, places, snacks)

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How does your child handle frustration?

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Does your child have regular responsibilities? Please describe.

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Educational History:

Does your child currently attend school? Please indicate school name, grade, and schedule.

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How is your child performing in school? Does your child enjoy school?

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Has your child's teacher expressed any concerns?

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Does your child receive any special services at school? Does your child currently have an Individualized Educational Plan (IEP)?

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Does your child receive any therapy services (speech therapy, feeding therapy, occupational therapy, physical therapy)?

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\*What is your purpose for initiating this evaluation?

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*Thank you for taking the time to complete this form*