



## Child Intake Form / History

Client Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 □ 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 [Private Practice / Private Practitioner Name]?  
 \_\_\_\_\_

### **Family Background**

Parent 1 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Education Level: \_\_\_\_\_  
 Parent 2 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Education Level: \_\_\_\_\_  
 Marital Status: □Single □Married □Divorced □Separated □Widowed

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: \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

---

---

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: _____           |
| 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    51-100    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
- Aggression
- Answering simple questions
- Understanding people
- Excessive drooling
- Producing speech sounds
- Reading
- Remembering
- Transitions
- Frustration Tolerance
- Anger
- Answering –wh questions
- Following directions
- Chewing or eating
- Stuttering
- School work
- Maintaining eye contact
- Word Retrieval

Other difficulties: \_\_\_\_\_

Please describe any of the above: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

---

---

---

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: \_\_\_\_\_





Christina Bennett M.S. CCC/SLP  
[Christina.bennett@sayitsow.com](mailto:Christina.bennett@sayitsow.com)  
[256-715-1249]

\_\_\_\_\_

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

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

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

Person filling out the form: \_\_\_\_\_  
Relationship to the child: \_\_\_\_\_



Christina Bennett M.S. CCC/SLP  
[Christina.bennett@sayitsow.com](mailto:Christina.bennett@sayitsow.com)  
[256-715-1249]

Child Intake Form / History