Global Speech
THERAPY

Speech Therapy Intake Form

Last Name: _____ MI: ___ First Name:_____
Date of birth: ___/___/_____ Sex: M F
Address:_____
_____
Home phone: (___)____-_____ Primary E-mail Address: _____
Primary Language: _____ Other Language(s): _____

Caretaker 1: Relationship: _____ Last Name: _____ First Name: _____
Cell phone: (___)____-_____ Work phone: (___)____-_____
Occupation: _____ E-mail Address: _____

Caretaker 2: Relationship: _____ Last Name: _____ First Name: _____
Cell phone: (___)____-_____ Work phone: (___)____-_____
Occupation: _____ E-mail Address: _____

Who referred you to our organization?_____
Primary Physician: _____ Phone #: _____

Other children in the family: Name Age Grade
_____
_____

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? Yes No
If yes, please describe:
_____
_____
_____
Was the mother sick during the pregnancy? Yes No
If yes, please describe:
_____
_____
_____
How many months was the pregnancy?_____
Did the child go home with his/her mother from the hospital? Yes No
If the child stayed in the hospital, please describe why and how long:_____
Was the delivery vaginal or by Caesarean section?_____
What was the child's weight and general condition at birth?_____

Global Speech
THERAPY

MEDICAL HISTORY

Medical Diagnosis (if applicable):

_____

Has your child had any of the following?

Adenoidectomy
- ❑ Encephalitis
- ❑ Seizures
- ❑ Allergies
- ❑ Flu
- ❑ Sinusitis
- ❑ Breathing difficulties
- ❑ Sleeping difficulties
- ❑ Chicken pox
- ❑ Thumb/finger sucking habit
- ❑ Measles
- ❑ Tonsillectomy
- ❑ Ear infections

How often?_____

- ❑ Meningitis
- ❑ Tonsillitis
- ❑ Mumps
- ❑ Vision problems
- ❑ Ear tubes
- ❑ Scarlet fever
- ❑ Colds
- ❑ High Fevers
- ❑ Head injury

If your child has allergies, please list:_____

_____

Other serious injuries/surgeries:_____

_____

Is your child currently (or recently) under a physician's care? Yes No

If yes, why?

_____

_____

Please list any medications your child takes regularly:

_____

_____

DEVELOPMENTAL HISTORY

Please state the approximate age your child achieved the following developmental milestones:

_____ Rolling
_____Grasped crayon
_____ Sat up alone
_____Stopped using pacifier
_____Self-fed with utensils
_____ Crawled
_____Said first words
_____Walked
_____Uses short sentences
_____Babbled
_____ Toilet trained
_____ Stood Up

Does your child…

- ❑ Choke on food or liquids?
- ❑ Currently put toys/objects in his/her mouth?

❏ Brush his/her teeth and/or allow brushing?

SPEECH-LANGUAGE HISTORY

Is there a language other than English spoken at home? Yes No If yes, please specify:

_____

Does the child speak the language? Yes No
Does the child understand the language? Yes No
What language does the child prefer to speak at home?

_____

Do you feel your child has a speech-language disorder? Yes No
If yes, please describe:

_____

_____

Do you feel your child has a hearing disorder? Yes No If yes, please describe:

_____

_____

Has your child ever had a speech evaluation/screening? Yes No
If yes, when and where? _____
What were you told?

_____

_____

Has your child ever had speech therapy? Yes No If yes, when and where?

_____

What was he/she working on?_____

_____

_____

Has your child received any other evaluation/therapy (e.g. physical therapy, occupational therapy, vision therapy)? Yes No
If yes, please describe:

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?

_____

_____

_____

What are your child's preferred activities/toy(s)_____

CURRENT SPEECH-LANGUAGE

Global Speech
THERAPY

Does your child…

- ❏ Repeat sounds, words or phrases over and over?
- ❏ Understand what you are saying?
- ❏ Retrieve/point to common objects upon request (ball, cup, shoe)?
- ❏ Follow directions (“Get your shoes” or “Bring the ball”)?
- ❏ Respond correctly to yes/no questions?
- ❏ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using…

- ❏ Body language/gestures
- ❏ Sounds (vowels, grunting)
- ❏ Words Sounds (vowels, grunting)
- ❏ Two to four word sentences
- ❏ Sentences longer than four words
- ❏ Augmentative and Alternative Communication (AAC) device
- ❏ Other _____

Behavioral characteristics:

- ❏ Cooperative
- ❏ Restless Attentive
- ❏ Poor eye contact
- ❏ Willing to try new activities
- ❏ Easily distracted/short attention
- ❏ Plays with a variety of toys
- ❏ Destructive/aggressive
- ❏ Separation difficulties
- ❏ Withdrawn
- ❏ Easily frustrated/impulsive
- ❏ Inappropriate behaviors
- ❏ Stubborn
- ❏ Self-abusive behaviors

Social-Emotional Behavior Characteristics:

Response to environment:

- ❏ Poor safety awareness
- ❏ Appropriate response to stimuli
- ❏ Appears unaware of objects
- ❏ Appears aware of objects
- ❏ Appears unaware of people
- ❏ Appears aware of people
- ❏ Brief eye contact

- ❏ Provides eye contact

Approach to task:

- ❏ Independent play
- ❏ Impulsive Says “I can’t”
- ❏ Disorganized

Direction following:

- ❏ Follows verbal directions
- ❏ Follows visual directions
- ❏ Follows physical directions
- ❏ Unable to follow directions
- ❏ Follows 1 step directions
- ❏ Follows 2 step directions

Attention to task:

- ❏ Appropriate
- ❏ Distractible
- ❏ Not focused

Alertness:

- ❏ Engaged by environment
- ❏ Not engaged by environment

Transitions:

- ❏ Able to transition easily
- ❏ Unable to transition easily

My child’s behaviors consist of:

_____

_____

What are your primary concerns/goals?

_____

_____