

TRAFFORD SPEECH, LANGUAGE AND LITERACY SERVICES, INC.

Pediatric Speech and Language Intake Form

1) Contact Information

Child's Name: _____ Date of Birth: _____ Age: _____

1st Caregiver Name _____

Relationship to child: _____ Age: _____

Level of Education _____

Occupation: _____

Address: _____

Phone Number: _____ E-mail: _____

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

2nd Caregiver Name _____

Relationship to child: _____ Age: _____

Level of Education _____

Occupation: _____

Address: _____

Phone Number: _____ E-mail: _____

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

Child's Pediatrician Information

Name: _____

Address: _____

Phone Number: _____

Medical Insurance

Insurance Carrier _____

Insurance Number _____

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II) Family Information

Siblings living in the same home: (Please include age/grade level)

Siblings living outside the home: (please include age and occupation)

Language(s) spoken in the home:

Primary language spoken with the child:

*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)

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

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

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

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III) Prenatal and Birth History

Length of pregnancy: _____ Length of labor: _____

C-section: Yes / No Birth Weight: _____ Apgar Score _____

Please explain any complications at birth:

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

IV) Child's Medical History

Chronic colds/respiratory infections Chronic ear infections

Asthma Allergies High fever Influenza

Please explain briefly:

Is your child taking any medications? If so, please state the name of the medication and condition used for; also describe duration, frequency of use and side effects.

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

Additional health information:

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V) Developmental History

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

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

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

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

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

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

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

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

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?

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

How does your child show frustration?

Does your child have regular responsibilities? Please describe.

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VI) Educational History

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

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

Has your child's teacher expressed any concerns?

Does your child receive any special services at school? Does your child currently have an Individualized Educational Plan (IEP) or 504 Plan?

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

What changes/improvements would you like to see in your child?

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WAIVER/INFORMATION SHARING

By Signing this form, I give permission for my child's doctor, teacher, other care providers to share information with professional affiliates of Trafford Speech, Language and Literacy Services, Inc. I also understand that I am responsible for payment at the time of service.

Signature

Date

I give permission to have my child photographed or videotaped for:

_____ office use only;

_____ for office and possible advertisement/publication

_____ I do NOT give permission to have child photographed or videotaped for any other purpose than therapy related
