Child First Speech, LLC. 

Intake Form

# Child’s Name: DOB:

# CHILD HISTORY –(Please complete the form to the best of your ability. If the question does not apply, leave blank)

#

# What are your concerns regarding your child’s speech and/or language?

#

#

# When did you first notice the issue(s)?

#

#

# Do you feel that your child’s speech and/or language is different than children his or her own age? If so, how?

#

#

#  Has your child ever received a speech language evaluation?

# When? How has this issue changed since you first noticed it?

#

#

#

# Siblings: Names & Ages

# Are there any family members or relatives who have or had any speech, language, or hearing issues or therapy?

#

#

# **Pregnancy, Birth History and Early Development**

# During pregnancy/birth with this child, were there any medical problems?

#

# Type of Delivery: Vaginal or Caesarian

#

# Was feeding a problem after birth? If so explain

#

# Bottle fed? Breast fed? Age weaned from breast? Weaned from bottle?

#

# Age drank independently from an open cup: finger fed self:

# Is your child able to eat with a spoon and fork? Does your child have any problems eating now?

#

# Does your child eat: Pureed foods? Yogurt/Pudding? Crunchy foods? Cookies/Pretzels?

#

# When did your child first learn to: Crawl? Sit alone? Feed self? Dress self? Walk independently?

#

# How well does your child: Walk? Run? Throw a ball?

# If your child has difficulties with any of the above or any other motor activities, please explain:

#

#

# Is your child potty trained?

#

#

# Has your child ever been hospitalized? Age and reason:

#

#

# Has your child ever had any serious illnesses or accidents? Explain

#

#

# Does your child have problems hearing? Ear Infections? If so, how many? Last hearing exam date and results:

# Does your child have any vision problems?

#

# Does your child have any trouble sleeping at night? Waking up in the morning? Explain:

#

# Does your child have allergies or asthma?

#

#

# List any medications your child is on:

#

#

# Is your child presently being treated by a pediatrician? ENT? Psychologist? Therapist? Neurologist? Physical Therapist? Occupational Therapist?

#

# Any other pertinent medical history?

#

#

#

#  **Speech History**

#

# Was your child very quiet as a baby? Did he/she coo? Babble? Did your child cry excessively as a baby?

# When did your child speak single words (other than “mama” or “dada”):

# What were your child’s first few words?

# Approximately how many words did your child have at around 18 months?

#

# When did your child begin to combine words (two words)?

#

#

# Does your child get frustrated by his/her difficulty or inability to communicate?

#

# Does your child speak in complete sentences?

#

# Please state any additional information or comments you feel would helpful to me in evaluating your child’s speech/language behavior:

I look forward to meeting you and your child!

Thank you,
Heidi Patterson, M.A., CCC-SLP