

Client Intake Form

Section A : Client Information

Any repetitive information can be noted with "Same".

Client Full Name:	
Social Security Number:	
Date of Birth:	
Gender / Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Language(s) Spoken in the home:	
Primary Address:	
Apt /Bldg #	
City / State:	
Zip Code:	
Referred By:	

SCHOOL Information	
Name of School:	
Address of School:	
Primary Teacher's Name:	
Grade/Class Child is in:	
Regular Ed OR Special Ed:	

DAYCARE Information	
Name of Daycare:	
Address of Daycare:	
Primary Daycare Teacher's Name:	
Grade/Class Child is in:	

Regular Ed OR Special Ed:	

Section B : Insurance Information
 Any repetitive information can be noted with "Same".

Primary INSURANCE Information	
Primary Insurance:	
Primary Policy Holder's Name:	
Contract Number:	
Group Number:	
Group Name:	
Co-Pay:	
Any Contact Information: (Usually found on back of insurance card.)	

Secondary INSURANCE Information	
Secondary Insurance:	
Secondary Policy Holder's Name:	
Contract Number:	
Group Number:	
Group Name:	
Co-Pay:	
Any Contact Information: (Usually found on back of insurance card.)	

Section C : Parent / Guardian Information
 Any repetitive information can be noted with "Same".

Primary GUARDIAN Information	
Parent/Guardian Full Name:	
Relationship to child: (Please Circle correct terms.)	Biological / Foster / Adopted Mother / Father / Grandmother / Grandfather / Aunt / Uncle / Sibling / (Other) _____
If Adopted, at what age was the child adopted?	
Home Address:	
Apt / Bldg # (if applicable)	
City / State:	
Zip:	
Cell Phone:	
Home Phone:	
Work Phone:	
Primary Email:	
Secondary Email:	
Employer:	
What are your major concerns regarding your child?	
<div style="border: 1px solid black; height: 100px; width: 100%;"></div>	
Have you consulted other professionals regarding these concerns?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Please explain below. (Pediatrician, Neuropsychologist, learning specialist, etc.)	

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Secondary GUARDIAN Information	
Parent/Guardian Full Name:	
Relationship to child: (Please Circle correct terms.)	Biological / Foster / Adopted Mother / Father / Grandmother / Grandfather / Aunt / Uncle / Sibling / (Other)_____
If Adopted, at what age was the child adopted?	
Home Address:	
Apt / Bldg # (if applicable)	
City / State:	
Zip:	
Cell Phone:	
Home Phone:	
Work Phone:	
Primary Email:	
Secondary Email:	
Employer:	
What are your major concerns regarding your child? <input type="checkbox"/> Concerns are the same as the Primary Guardian's Concerns.	

Have you consulted other professionals regarding these concerns?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Please explain below. (Pediatrician, Neuropsychologist, learning specialist, etc.)	
<input type="checkbox"/> Consulted with the same professionals the Primary Guardian consulted with.	

If custodial parents/guardians live separately...

Please describe current timeshare / custody schedule in the table below.

Day	Resides with which Guardian?	At School or Daycare between which hours?
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Details / Specifics:		

Section D : Current Medications

Any repetitive information can be noted with "Same".

Please include all prescription and nonprescription medications, herbs, vitamins, hormones, etc.

Medication Name	Dosage	Intended to Treat what?	Who Prescribed Drug?
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Additional medications and explanations:

Section E : Client History

Any repetitive information can be noted with "Same".

Primary PHYSICIAN Information	
Referring Doctor's Office / Practice:	
Address:	
Phone Number:	
Fax Number:	
DIAGNOSIS (IF KNOWN):	

Client MEDICAL History (Check all that apply)		
<input type="checkbox"/> Chronic Colds/respiratory infections	<input type="checkbox"/> Temporary Hearing Loss	<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Allergies
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Attention Deficit Disorder (ADD / ADHD)	
<input type="checkbox"/> High Fever	<input type="checkbox"/> Previously diagnosed global developmental delay	
Please list any other serious illness or condition here:		
Please list and explain any hospitalizations for illness or operations here:		
Please list any allergies your child has here:		

Developmental Issues and Experiences Please check all that apply or did apply to your child.	
<input type="checkbox"/> Separation from parents for a long time	<input type="checkbox"/> Avoidance of eye contact
<input type="checkbox"/> Frequent hospitalization	<input type="checkbox"/> Nonresponsive when spoken to
<input type="checkbox"/> Resistance to cuddling	<input type="checkbox"/> Unusual play methods
<input type="checkbox"/> Difficult to calm	<input type="checkbox"/> Failure to develop gestures (bye-bye)

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<input type="checkbox"/> Colicky	<input type="checkbox"/> Failure to point or request
<input type="checkbox"/> Restless	<input type="checkbox"/> Failure to coo or babble
<input type="checkbox"/> Inactive	<input type="checkbox"/> Difficulty sharing
<input type="checkbox"/> Difficulty eating	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Accident prone	<input type="checkbox"/> Other (explain in space below)

What was the *approximate* age that your child...
 (Put N/A if behavior has not happened yet.)

Pointed (joint attention):	<input type="text"/>
Smiled:	<input type="text"/>
Sat without support:	<input type="text"/>
Crawled:	<input type="text"/>
Walked with assistance:	<input type="text"/>
Spoke first words:	<input type="text"/>
Spoke in phrases:	<input type="text"/>
Spoke in sentences:	<input type="text"/>
Self fed using finger food:	<input type="text"/>
Self fed using cup/spoon:	<input type="text"/>
Potty trained/by day:	<input type="text"/>
Dressed self:	<input type="text"/>

Please check all that apply when it comes to your child's development:

<input type="checkbox"/> Repeat sounds, words, or phrases over and over	<input type="checkbox"/> Understanding what you are saying
<input type="checkbox"/> Respond correctly to who/what/when questions	<input type="checkbox"/> Follow simple directions
<input type="checkbox"/> Retrieve/point to common objects when requested	<input type="checkbox"/> Respond correctly to Yes/No questions

How does your child currently communicate?		
<input type="checkbox"/> Body language	<input type="checkbox"/> Sounds (vowels, gurgling)	<input type="checkbox"/> Words (shoe, doggy)
<input type="checkbox"/> 2 to 4 word sentences	<input type="checkbox"/> Sentences longer than 4 words	<input type="checkbox"/> Other (please explain)

Speech and Language Development
At what age did you first become concerned about your child's speech?
What caused your concern?

Sensory Issues
Do you have any concerns about your child's sensory processing skills? (Sensitivity to loud sounds, touch, taste, or smell, toe walking, etc.)
<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please explain below:

Feeding Issues		
Does your child have any problems with drinking liquid or eating various textures that result in any of the following:		
<input type="checkbox"/> Choking	<input type="checkbox"/> Vomiting after eating	<input type="checkbox"/> Gagging
<input type="checkbox"/> Difficulty eating certain textures	<input type="checkbox"/> Taking more than 30 min to eat	<input type="checkbox"/> Currently see feeding specialist
<input type="checkbox"/> Other Feeding Issues (please explain)		

Comprehension Issues
Do you believe that your child understands and requests as well as other children his/her age? <input type="checkbox"/> No <input type="checkbox"/> Yes
If no, please explain below:

Social Interaction and Behavioral Concerns
Please describe any and all behavioral concerns at home or in school:

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Peer Relationships

Does your child seek friendship with peers?	<input type="radio"/> Yes <input type="radio"/> No
Is your child sought by peers for friendship?	<input type="radio"/> Yes <input type="radio"/> No
Does your child play primarily with children his/her own age	<input type="radio"/> Yes <input type="radio"/> No

If no, Younger Older

Briefly describe any problems/concerns you have regarding your child's peer relationships:

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Additional children present in your child's home(s).

Child's Name	Age	Relationship to client (brother, sister, step-sibling, etc)

Do any of these children have developmental delays? If yes, please explain below.

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Please provide any further information you feel would be helpful regarding your child.

I, _____, assure Speech Therapy Solutions, LLC that all the information, data, and material provided by me on this client intake form is accurate and true.

Guardian / Caretaker Signature _____

Date ____/____/____