Child Intake Form / History

Today's Date _____
Client Name: _____ Nickname: _____
Date of Birth: _____Age: ___☐Male ☐Female ☐Prefer Not To Respond
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 Branched Out Therapy, Inc. ?

_____

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 ☐Step Parent
☐Other:_____

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____ Age: ___Sex: ___ Speech Concerns:_____
Child 2 Name: _____ Age: ___Sex: ___ Speech Concerns:_____
Child 3 Name: _____ Age: ___Sex: ___ Speech Concerns:_____

Child 4 Name: _____ Age: ___Sex: ___ Speech Concerns:_____
Child 5 Name: _____ Age: ___Sex: ___ Speech Concerns:_____
Child 6 Name: _____ Age: ___Sex: ___ Speech Concerns:_____

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: _____
_____
_____

Please upload copies of any previous evaluations, progress reports, or IEP's. You may also bring them in at our first meeting.

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 Concerns 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 Concerns 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, about 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 ☐Frustration Tolerance
☐Aggression ☐Anger
☐Answering simple questions ☐ Answering –Wh questions
☐ Understanding people ☐ Following directions
☐ Excessive drooling ☐Chewing or eating
☐Producing speech sounds ☐Stuttering
☐Reading ☐School work
☐Remembering ☐Maintaining eye contact
☐Transitions ☐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: _____

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: _____

Child Intake Form / History