



Speech Within Reach Therapy Services

Phone: 727-493-2393

Fax: 844-714-2504

Email: Therapy@swrtherapy.com

Website: swrtherapy.com

Child Intake Form / History

Client Name: _____ Today's Date _____
Nickname: _____
Date of Birth: _____ Age: _____ Male Female
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 [Private Practice / Private Practitioner Name]?

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 Parent 1 Only
- Parent 2 Only Other: _____

Does the child have siblings or are there other siblings in the home?

- Child 1 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
- Child 2 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
- Child 3 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
- Child 4 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
- Child 5 Name: _____ Age: ___ Sex: ___ Speech Issues: _____

Language(s) are 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: _____



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:

- | | |
|---|-----------------|
| <input type="checkbox"/> Adenoidectomy | Describe: _____ |
| <input type="checkbox"/> Asthma | Describe: _____ |
| <input type="checkbox"/> Behavior Issues | Describe: _____ |
| <input type="checkbox"/> Brain injury | Describe: _____ |
| <input type="checkbox"/> Breathing problems | Describe: _____ |
| <input type="checkbox"/> Cardiac issues | Describe: _____ |
| <input type="checkbox"/> Chicken pox | Describe: _____ |
| <input type="checkbox"/> Diabetes | Describe: _____ |
| <input type="checkbox"/> Ear infections | Describe: _____ |
| <input type="checkbox"/> Ear tubes | Describe: _____ |
| <input type="checkbox"/> Encephalitis | Describe: _____ |
| <input type="checkbox"/> Frequent colds | Describe: _____ |
| <input type="checkbox"/> High fever | Describe: _____ |
| <input type="checkbox"/> Measles | Describe: _____ |
| <input type="checkbox"/> Meningitis | Describe: _____ |
| <input type="checkbox"/> Mumps | Describe: _____ |
| <input type="checkbox"/> Seizures | Describe: _____ |
| <input type="checkbox"/> Sensory issues | Describe: _____ |
| <input type="checkbox"/> Sleep issues | Describe: _____ |
| <input type="checkbox"/> 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: _____



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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 / Psychologist _____

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, 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



- | | |
|---|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Answering simple questions | <input type="checkbox"/> Answering –wh questions |
| <input type="checkbox"/> Understanding people | <input type="checkbox"/> Following directions |
| <input type="checkbox"/> Excessive drooling | <input type="checkbox"/> Chewing or eating |
| <input type="checkbox"/> Producing speech sounds | <input type="checkbox"/> Stuttering |
| <input type="checkbox"/> Reading | <input type="checkbox"/> School work |
| <input type="checkbox"/> Remembering | <input type="checkbox"/> Maintaining eye contact |
| <input type="checkbox"/> Transitions | <input type="checkbox"/> Word Retrieval |
| <input type="checkbox"/> 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: _____



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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? _____



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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: _____