BEYOND SPEECH

THERAPY SERVICES

Intake Form

This form is to be completed prior to evaluation when possible.

Client Name:	**Client DOB:**
Home address:	
Email:	**Phone:**
Referred by:	
Form completed by:	**Relationship:**

Please describe specific concerns for this evaluation regarding speech and language, or swallowing:

Primary language:	☐ English ☐ Other: _____
Other languages spoken:	

Family Information/History

Please list current members of the household

Name:	Age:
Name:	Age:
Name:	Age:
Name:	Age:

Name:	Age:
Name:	Age:

Do any immediate or extended family members have a history of:

Language Disorders? (e.g. late talker, speaking or understanding language)	☐ Yes ☐ No
Articulation Disorders? (e.g. trouble saying the r sound)	☐ Yes ☐ No
Fluency Disorders/Stuttering?	☐ Yes ☐ No
Motor Disorders? (e.g. cerebral palsy)	☐ Yes ☐ No
Genetic Disorders? (e.g. Down syndrome)	☐ Yes ☐ No
Autism?	☐ Yes ☐ No
Hearing loss?	☐ Yes ☐ No
If yes, please describe:	

Please list pets currently living in the home

Name:	Breed:
Name:	Breed:
Name:	Breed:
Name:	Breed:

Have there been any major changes that may have affected the client (such as family death, change in work schedule, child care or marriage status)? If yes, explain:	☐ Yes ☐ No
Does the client attend school or work? If yes, where:	☐ Yes ☐ No
Does the client participate in any other community activities? (e.g. team sports, volunteering, clubs) If so, what activities?	☐ Yes ☐ No
Please list some of the client's favorite activities/interests? (favorite shows, hobbies, favorite toys, etc)	

Medical History

In the past 3 years, has the client had any of the following: serious illnesses, accidents, hospitalizations, or surgery?	☐ Yes ☐ No

If yes, please explain:	
In the past 3 years, has the client taken any medication prescribed by a doctor? If yes, list name of medication, date, and reason for taking it	☐ Yes ☐ No
Please list the client's current medications:	
Does the client receive ongoing medical care for any condition? If yes, please explain.	☐ Yes ☐ No
Has the client seen a dentist in the past year?	☐ Yes ☐ No

Hearing

Has the client's hearing been tested by an audiologist?	☐ Yes ☐ No

If yes, please provide the date and results of the hearing examination.

Is there a history of challenges regarding hearing? (hearing loss, ear infection, tubes, fluid) If yes, explain.	☐ Yes ☐ No

Current Language Abilities

Please circle the phrases that describe how the client communicates (circle all that apply)

Pointing/other gestures	Babbling	Manual Sign (or ASL)
Single Words	Two Word Combinations	Sentences with some errors
3-4 word phrases	Grammatically correct sentences	Tells stories, explains what happened
Other:		

Has the client ever received speech therapy in the past? If yes, please explain.	☐ Yes ☐ No

For Clients Under 18 years

Birth History

Was the pregnancy full term? If no, how many weeks?	☐ Yes ☐ No
Were there any complications during birth or pregnancy? If yes, please explain.	☐ Yes ☐ No
Were there any medical problems detected during birth? If yes, please explain.	☐ Yes ☐ No
Did your child require time in the NICU? If yes, how long?	☐ Yes ☐ No

Indicate the age that your child met the following milestones (if unknown, please estimate)

Sitting independently	Age:
Crawling	Age:
Walking	Age:
Babbling	Age:
First Words	Age:
Combining words	Age:

Current Language Abilities

Responds to name	☐ Yes ☐ No ☐ Sometimes

Points to object when asked	☐ Yes ☐ No ☐ Sometimes
Follows simple directions	☐ Yes ☐ No ☐ Sometimes
Comments or asks questions during activities	☐ Yes ☐ No ☐ Sometimes
Answers simple questions	☐ Yes ☐ No ☐ Sometimes
Understands prepositions (e.g. in, on, under)	☐ Yes ☐ No ☐ Sometimes
Understands colors/size (e.g. red, big, small)	☐ Yes ☐ No ☐ Sometimes
Engage in imaginary play	☐ Yes ☐ No ☐ Sometimes
Sits and attends to activities (e.g. can complete homework, play with a toy for extended amount of time, etc)	☐ Yes ☐ No ☐ Sometimes

Other

Are you concerned about your child's behavior (at home or at school), diet, or sleep habits? If yes, please explain.	☐ Yes ☐ No

Does your child socialize/ play with other children?	☐ Yes ☐ No
Does your child ignore you when you are speaking? If yes, please describe:	☐ Yes ☐ No

Please tell us anything else that will help us when working with your child: