FUNctional Pediatric Therapy

Speech Therapy Patient Intake Form

Patient's Information:

Today's Date: _____

Patient's Name: _____ DOB: _____ Age: _____ M/F:_____

Parent/Guardian Name: _____

Home Address: _____ Phone: _____

Email Address: _____

Referral Information:

Who referred this child for an evaluation: _____

Reason for Referral: _____

What are your primary concerns/goals for therapy:

_____

_____

_____

_____

What are you child's strengths:

_____

_____

_____

_____

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School History:

Name of School: _____ Grade: _____ Teacher: _____

Does your child receive special instruction or have an established IEP? YES NO

Does your child receive school-based therapy? (circle all those that apply) OT PT ST

Medical History:

Any difficulties during pregnancy or delivery? YES NO

If yes, please specify:

_____

_____

_____

_____

Length of Pregnancy: _____ Birth was: Vaginal Cesarean Breech

Chronic ear infections: YES NO Tubes placed: YES NO If yes, how many sets of tubes: _____

List Current Medications:

_____

_____

_____

_____

Food Allergies:

_____

_____

_____

_____

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Special Diet:_____

Medical Precautions:_____

Current Diagnosis: _____

Any Hospitalizations: YES NO If yes, date and length of stay: _____

Any Surgeries: _____

Is the patient currently receiving services from any other healthcare provider (Occupational Therapy, Nutritionist, Behavioral Specialist, etc):

_____

Communication:

Describe the concerns you have about your child's communication at this time:_____

_____

_____

When was the communication difficulty first noticed and who noticed it:_____

_____

Are there any skills that your child has learned previously, but can no longer use? If so please explain:

_____

_____

_____

Has the child's hearing been tested? YES NO

If yes, where was the test completed:_____ Date of completion: _____

Results: ☐ Hearing within normal limits ☐ Hearing Loss ☐ Further testing required

Have any family members had any speech, language, hearing problems, or learning difficulties: YES NO

If yes, who?_____ Please Describe:_____

_____

What languages are spoken at home: _____

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What is the child's primary language: _____

How does your child usually communicate (please check all that apply):

☐ Gestures ☐ Single words ☐ Short phrases ☐ Sentences

In which situations does your child have more difficulty communicating (circle all that apply):

At Home At Daycare/Preschool At School With Friends Everywhere

Has the problem changed since it was first noticed: _____

Approximately hoe much of your child's speech do you understand?

____Less than 10% ____25% ____50% ____75% ____90-100%

Approximately how much of your child's speech do those less familiar with the child understand?

____Less than 10% ____25% ____50% ____75% ____90-100%

Developmental History:

Please specify an age for all the developmental milestones that your child has achieved:

Rolling: _____ Crawling: _____ Sitting alone: _____ Pull-to-stand: _____ Walking: _____

First words: _____ Finger feeding: _____ Eating with spoon: _____ Cutting with scissors: _____

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers:

Activity:	Age:	Earlier than Peers:	Same Time as Peers:	Later than Peers:
Babbling (e.g. "ba ba")				
Use first words				
Put 2-3 words together				
Make sentences				
Put sentences together				

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Engage in conversation				
Understand directions				

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Please describe your child at present:

Descriptor:	Yes:	No:	Sometimes:	Mostly:
Overly Active				
Tires Easily				
Talks constantly				
Acts impulsively				
Restless				
Stubborn				
Resistance to change				
Fights frequency				
Usually happy				
Clumsy				
Exhibits tantrums				
Nervous habits				
Wets the bed				
Poor attention				
Frustrated easily				
Unusual Fears				
Difficulty going to sleep				
Difficulty staying asleep				
Sluggish in the mornings				

Anything else you would like us to know about your child:_____

_____

_____

_____

_____

_____

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