Child Intake Form

1. Demographic Information

Gender: ☐Male ☐Female

Client's Name:______________________________ **Birth Date:**_____/_____/_____
First Last MI Month Day Year

Home Address:______________________________ Daycare/School: ____________________

Primary Caregiver's Name: ______________________________ Relationship to client:____________________

Phone Number:______________________________ Email Address: ______________________________

Are text messages OK at this #: ☐**Yes** ☐**No**

Secondary Caregiver's Name: ______________________________ Relationship to client:____________________

Phone Number:______________________________ Email Address: ______________________________

Are text messages OK at this #: ☐**Yes** ☐**No**

Client's Pediatrician Name: ______________________________ Pediatrician's Phone: ____________________

Primary Insurance: ______________________________ Policy Number: ______________________________

Primary Language: ______________________________ Secondary Language: ______________________________

Who does the client live with?

- ☐ Mother
- ☐ Father
- ☐ Grandparent(s)
- ☐ Older Sibling(s)
- ☐ Younger Sibling(s)
- ☐ Twin Sibling(s)
- ☐ Aunt/Uncle(s)
- ☐ Other: ______________________________

Does the client attend school/daycare?

☐No ☐Yes If yes, where do they attend? ______________________________ Grade/Class: ____________________

Days/Hours they attend:______________________________Do they receive therapy services at school? ☐No ☐Yes

What are the caregiver's concerns about the client? (please check all that apply)

- ☐ Speech sound production (articulation)
- ☐ Expressing and understanding language
- ☐ Social skills
- ☐ Swallowing function
- ☐ Eating/Drinking skills
- ☐ Breast/Bottle Feeding
- ☐ Stuttering/fluency
- ☐ Delayed gross motor skills (rolling, walking)
- ☐ Delayed fine motor skills (grasping, writing)
- ☐ Tongue-tie/lip tie
- ☐ Sensory differences
- ☐ Other ______________________________

Has the client been evaluated for the above concerns?

☐No ☐Yes If yes, when was the evaluation? ____

2. Birth History

How many weeks gestation was the client born?____________weeks ☐Unknown

What was the client's birth weight? __________,__________ ☐Unknown
Pounds **Ounces**

How was the client delivered? ☐ Vaginal Delivery ☐Cesarean Section ☐Unknown

Were there any birth complications?

- ☐ Assisted delivery
- ☐ Jaundice
- ☐ Intubation
- ☐ NICU (length of stay: _________________)
- ☐ Preeclampsia
- ☐ Hypoxia
- ☐ Nuchal Cord
- ☐ Other: ______________________________

3. Medical History

Has the client ever been diagnosed with a medical condition, syndrome, or disorder?

☐No ☐Yes. Please specify: ____ ☐Unknown

Has the client ever been diagnosed with tongue, lip or cheek ties?

☐No ☐Yes. Please specify type/if released: ____

Does the client have any allergies (specifically to food or latex)?

☐No ☐Yes. Please specify: ____ ☐Unknown

Is the client up-to-date on their vaccines?

☐No ☐Yes ☐Unknown

Is the client currently taking any medications?

☐No ☐Yes. Please specify the type(s) and what it is taken for below:

Has the client ever had their hearing tested?

☐No ☐Yes. Please specify type of test and pass/fail: ____________________________________☐Unknown

Does the client have a history of ear infections and/or tubes?

☐No ☐Yes. Please specify: ____

4. Development History

How does the client currently communicate?

☐ Spoken language
☐ Gestures
☐ Sign language
☐ Pointing to pictures
☐ Picture exchange communication
☐ Other: ________________________________

How well do *familiar* listeners understand the client when they are speaking?

☐ Less than 25% of the time
☐ 25% - 50% of the time
☐ 50% - 75% of the time
☐ 75% - 90% of the time
☐ 90% - 100% of the time
☐ N/A

How well do *unfamiliar* listeners understand the client when they are speaking?

☐ Less than 25% of the time
☐ 25% - 50% of the time
☐ 50% - 75% of the time
☐ 75% - 90% of the time
☐ 90% - 100% of the time
☐ N/A

Does your child display any of the following?

☐ Lack of shared interests
☐ Limited gestures/pointing
☐ Guiding an adult's had to objects
☐ Dislike of things on hands
☐ Limited response to name
☐ Picky eating
☐ Self injurious behavior
☐ Aggression toward others
☐ Lack of eye contact
☐ Distress over change in routine
☐ Repetitive play/behaviors
☐ Overreactive to sounds
☐ Sensitive to being touched
☐ Aversion to smells/tastes
☐ Frequent temper tantrums/meltdowns
☐ Clumsiness

Are you concerned the client may display signs of autism spectrum disorder?

☐ No ☐Yes. Please specify: ____

Does the client currently display any of the following motor delays?

☐ Rolling
☐ Crawling
☐ Jumping
☐ Hopping
☐ Dressing/undressing
☐ Grasping
☐ Grabbing
☐ Pointing
☐ Self-feeding
☐ Eating/drinking
☐ Walking
☐ Running
☐ Writing
☐ Drawing
☐ Other: ________________________

How was the client fed for the first 6 months of life? (please check all that apply)

☐ Breastfed. Length of time: _______________ Complications: ___________________________

☐ Bottle-fed. Length of time: _______________ Complications: ___________________________

☐Tube-fed. Length of time: _______________ Type/Frequency: ___________________________

☐Other: ____

When were solid foods introduced to the client?

- ☐ Less than 4 months
- ☐ 4 months-5 months
- ☐ 6-7 months
- ☐ 8-9 months
- ☐ 10-11 months
- ☐ 12 months
- ☐ Over 12 months
- ☐ Not yet introduced
- ☐ Other: ____________________

Does the client demonstrate any of the following while eating/drinking?

- ☐ Choking
- ☐ Gagging
- ☐ Vomiting
- ☐ Coughing
- ☐ Eye watering
- ☐ Refusing foods/drinks
- ☐ Crying during mealtimes
- ☐ Difficulty sitting still for mealtimes
- ☐ Difficulty chewing
- ☐ Difficulty drinking from a cup/straw
- ☐ Difficulty biting food
- ☐ Difficulty touching food with hands
- ☐ Picky eating
- ☐ Hiccupping during mealtimes
- ☐ Lips turning blue
- ☐ Other: ______________________________

Please write below anything else you would like to share with us about the client:

Thank you for taking the time to fill out this intake form. All personal information collected by Sunny Speech Inc. (DBA Sunny Pediatric Services) for the purposes of providing services, assessing client needs and referring to services. Contact the (850) 909-5521 or office@sunnyspeech.com if you have questions about the use of your personal information.