



***Coral Gables, FL 33146 • Tel: 786-531-8841 • Email: selfexpressionstx@gmail.com***

## **Child Intake Form / History**

Today's Date \_\_\_\_\_

Client Name: \_\_\_\_\_

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 Self-Expressions Therapy?

\_\_\_\_\_

### **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) 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: \_\_\_\_\_

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At what age did you first notice the problem? \_\_\_\_\_

How do the child's communication difficulties impact the family? \_\_\_\_\_

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If anyone else in the family has a speech or language diagnosis, please describe it: \_\_\_\_\_

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Is the child aware of or frustrated by their communication difficulties? \_\_\_\_\_

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### **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:

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### *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:

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*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: _____ |
| <input type="checkbox"/> Tonsillitis            | Describe: _____ |
| <input type="checkbox"/> Tonsillectomy          | Describe: _____ |
| <input type="checkbox"/> Traumatic brain injury | Describe: _____ |
| <input type="checkbox"/> Vision issues          | Describe: _____ |

Is the child up to date with immunizations: ☐ Yes ☐ No

Please describe: \_\_\_\_\_

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Has the child ever had surgery? ☐ Yes ☐ No

Please describe: \_\_\_\_\_

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Has the child ever been hospitalized: ☐ Yes ☐ No

Please describe: \_\_\_\_\_

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Has the child ever been in a serious accident? ☐ Yes ☐ No

Please describe: \_\_\_\_\_

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Does the child have a chronic illness? If so, please describe: \_\_\_\_\_

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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: \_\_\_\_\_

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Does the child have a history of ear infections, tubes, etc. or use hearing aides?

☐ Yes ☐ No

Describe: \_\_\_\_\_

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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, 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:*

<input type="checkbox"/> Attention	<input type="checkbox"/> 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

☐ 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? \_\_\_\_\_

\_\_\_\_\_



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What are the child's favorite activities? \_\_\_\_\_

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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: \_\_\_\_\_

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Describe how the child interacts with other children: \_\_\_\_\_

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What are your goals for the child over the next 6 months? \_\_\_\_\_

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What are your goals for the child over the next 5 years? \_\_\_\_\_

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Is there anything else that is important for us to know about the child?

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Person filling out the form: *(print)* \_\_\_\_\_ *(sign)* \_\_\_\_\_

Relationship to the child: \_\_\_\_\_

