

Speak Freely

Speech–Language and Oral-Motor Services

INTAKE FORM

DEMOGRAPHIC INFORMATION

Child's Name: _____ Date: _____

Date of Birth: _____ Sex: _____ Age: _____

Parents/Guardians: _____

Mother's Name

Father's Name

Address: _____

No./Street

City/State

Zip Code

Home Phone #: _____ Work/ Mobile #: _____

E-Mail Address: _____

MEDICAL INFORMATION

Primary Care Physician: _____

Address: _____

Referred by: _____

Prescription provided: _____ Doctor concerned: _____

INSURANCE INFORMATION

Insurance Provider: _____

Insured's Policy Group, FECA, Medicaid #: _____

Insured's I.D./ SS #: _____

Employer's Name/ School Name: _____

Child's Relationship to Insured: _____

Siblings (include names and ages):

What languages are spoken in the home? What languages are spoken at school?

What languages does the child speak?

Describe the concerns regarding your child's speech-language skills:

CONCERNS (PLEASE CHECK ALL THAT APPLY TO YOUR CHILD)

- HEARING (has a hearing loss, seems to not hear information, needs repetition)
- SPEECH ARTICULATION (difficult to understand or poor sound production)
- EXPRESSIVE LANGUAGE SKILLS (unable to relay thoughts clearly)
- RECEPTIVE LANGUAGE SKILLS (difficulty following directions, concepts)
- ORAL MOTOR FUNCTIONING (drooling, tongue thrust, muscle strength)
- SWALLOWING/FEEDING (cough/chokes with food, decreased chewing)
- OTHER Please Explain:

How does your child usually communicate (gestures, single words, phrases, sentences)?

When was your child's speech language difficulties first noticed? By whom?

Does the child seem to be aware of his/her speech-language challenges?

Are there any other speech, language, or hearing problems in your family? If yes please describe.

MEDICAL & DEVELOPMENTAL HISTORY
MATERNAL HISTORY

Did the mother take medication during pregnancy? If yes what, why, when and for how long.

Did any of the following occur during pregnancy?

EXPLAIN

- Bleeding _____
- Rh incompatibility of parents _____
- Measles _____
- Accidents _____
- Illness/Infections _____
- Rashes _____

BIRTH HISTORY

How long was the mother's pregnancy? _____

Was labor induced? _____

What medications were given during birth and to whom? _____

How long was labor? _____ Were forceps used? _____

What was the child's apgar score? _____ What was the birth weight? _____

Explain any significant occurrences during the child's birth(i.e. trauma, cord wrapped around neck, jaundice, heart issues, feeding problems, need for medical attention/oxygen)

MEDICAL HISTORY

Has the child’s health been **good, fair** or **poor**? _____

- Please check any of the following occurrences: ear infections allergic reactions
 tubes in ears reflux rsv/pneumonia constipation
 special diet takes medicine regularly eczema seasonal allergies

EDUCATIONAL HISTORY

School child is currently attending: _____

Grade: _____ Teacher: _____

How is your child doing academically or preacademically?

How does the child interact with others (ie. shy, aggressive, uncooperative, etc.)?

Has the child received any therapies through school or any other setting? Please list all and provide dates of when they began and how long these therapies lasted.

Please circle the most appropriate response that describes your child.

Frequently (F) Occasionally (O) Never (N)

- | | |
|---|-----------|
| Has trouble completing tasks when the radio is on | F – O – N |
| Is distracted/ has trouble functioning if there is a lot of noise | F – O – N |
| Can’t work with environmental noise such as loud fan/vacuum | F – O – N |
| Appears to not hear what you say (tunes you out or ignores you) | F – O – N |
| Doesn’t respond when name is called | F – O – N |
| Cries or covers ears when hears loud noises | F – O – N |
| Enjoys music and noise and uses it to calm down | F – O – N |

DEVELOPMENTAL HISTORY

At what age did the child reach the following developmental milestones?

Sit unsupported _____ Crawl _____ Walk _____

Begin saying words _____ Put 2-3 words together _____

Answer questions or relate information verbally? _____

Bowel Control _____ Bladder control _____

Use toilet _____ Feed self _____ Stand _____ Dress self _____

Approximately how many words are in the child’s vocabulary: _____

Compared to siblings or peers, was speech development **fast**, **slow** or **average**?

FEEDING / ORAL-MOTOR HISTORY

Was the child breast-fed? **YES** **NO** How long? _____

Was the child bottle-fed? **YES** **NO** How long? _____

Has/does the child currently display any of the following difficulties?

- choking/gagging
- over stuffing of food
- spitting out of food
- drooling
- special diet
- spillage of food from mouth
- food texture preferences
- swallowing food whole
- poor chewing
- sticks tongue out when eating
- hard time using straw/cup
- food allergies
- dislikes face washing
- hates brushing teeth
- bites/chews non-food items

If the child has food/texture issues, which texture/temperature is most preferred?

Crunchy _____ Salty _____ Cold _____

Chewy _____ Sour _____ Hot _____

Semi-solid _____ Sweet _____ Warm _____

Pureed _____ Spicy _____ Room temp _____

Thick liquid _____

NOTES/COMMENTS
