INTAKE FORM

General Information:

Today's Date:_____
Child's Name: _____ DOB: _____
Grade: _____ School: _____ Age: _____
Address: _____
Phone: _____
Child lives with (give names please):_____
Relationship: _____
Caregiver Name (1): _____ DOB:_____
Caregiver Name (2):_____ DOB: _____
Pediatrician Name: _____ Phone: _____
Brothers and Sisters:_____
Referral Source: _____
Insurance Carrier: _____
Group Number:_____
MembberNumber:_____

Concerns regarding child (use additional paper if needed):
First Noticed Problem (first noticed by whom?): **Has the problem changed since first noticed?** **Is the child aware of his/her problems?**
Medical Diagnoses (list date of diagnosis and by whom the diagnosis was made.)**:**
Prenatal: Exposure to drugs or alcohol? Exposure to heavy metals? Accidents:

Illnesses:

Birth History:

Complications at birth?

Weight:

Hospitalization?

Developmental
At what age did your child……..

Crawl:	Walk:
Sit:	Feed Self:
Stand:	Dress Self:
Use Toilet:	Speak:

Speech/Language Development:
Does your child use ……
(please give examples)

Single Words:

Combine Words:

Name objects:

Use simple questions:

Follow simple directions

Speak in correct sentences

Fluent speech (“Tip-of-tongue syndrome”)

Medical History
Does your child have a history of……
(Please list approximate age of your child and treatment your child received)

Ear infections: Head injury:

High Fever: Seizures:

Surgeries: Allergies:

Other:

Any hospitalizations (why?, when? And where?)

Is the child currently taking any medication? (Type, dose and reason)

Has the child had a hearing test?
When?
By who?
Results:

Languages spoken in the home:

Primary language spoken by child:

How does the child usually communicate? (gestures, single words, short phrases, behavioral outbursts)

Who does the child usually spend time with?

Any Difficulties in:

Oral Motor/ Feeding (drooling, swallowing)

Gross Motor (running, walking)

Fine Motor (using scissors, writing)

Does your child experience academic difficulties?
(Please provide examples)

Rhyming
Reading
Comprehension (understands what he/she reads)
Decoding (can sound out words)
Writing
Spelling
Sentences
Narration

Describe your child's social skills:
Does your child have close friends?

Engage in imaginary play? (give examples)

Does your child have difficulty transitioning from tasks and/or environments?

Is your child overly sensitive to light, food, or sounds?

How is your child's attention?
Alone

In groups

In Class

Have any other specialists/special educators seen your child? If yes, who? When was your child seen and what were the recommendations of the specialist(s)?

What are your goals for the evaluation? What do you hope to learn from the results?

Please send copies of past medical records and/or educational reports that have been completed on your child. Please include homework samples.

Please return this questionnaire and relevant paperwork to:

Miller Speech/Language Pathology, Inc.
11837 Venice Loop NE
Bainbridge Island, WA 98110