INTAKE FORM

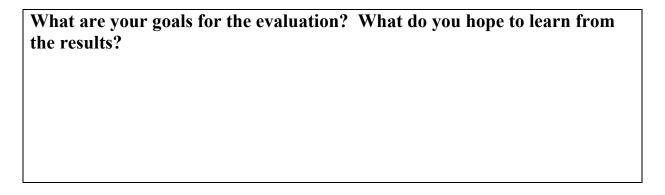
General Information:

Today's Date:		
Child's Name:	DOB:	
Grade: School:	Age:	
Address:		
Phone:		
Child lives with (give names please)	:	
Relationship:	DOD	
Caregiver Name (1):	DOR:	
Caregiver Name (2):	DOB:	
	Phone:	
Brothers and Sisters:		
Referral Source:		
Insurance Carrier:		
Group Number:		
MembberNumber:	<u></u>	
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 diagmade.):	gnosis and by whom the diagnosis was	
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 syn		

Medical History Does your child have a history of (Please list approximate age of your child		
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:		
Languages spoken in the nome.		
Primary language spoken by child:		
How does the child usually communic	ate? (gestures, single words, short	
phrases, behavioral outbursts)		
Who does the child usually spend time with?		
Any Difficulties in: Oral Motor/ Feeding (drooling, sv	wallowing)	
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)?



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