



CHILD INTAKE FORM

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST BEFORE YOUR INITIAL APPOINTMENT

CHILD'S INFORMATION			
FULL NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE	
INSURANCE CARRIER		MEMBER NUMBER	
DOES YOUR CHILD HAVE OREGON HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, MEMBER NUMBER	
DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs.			
How does your child react to being misunderstood or unable to communicate?	<input type="checkbox"/> Tries again/revises <input type="checkbox"/> Gives up	<input type="checkbox"/> Becomes angry/frustrated <input type="checkbox"/> Doesn't notice	<input type="checkbox"/> Other:
Why are you seeking speech-language services for your child?			
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?			
How did you learn about us?			
In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. <input type="checkbox"/> None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	<input type="checkbox"/> Biological parent(s) <input type="checkbox"/> Adoptive parent(s) <input type="checkbox"/> Legal guardian(s) <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Other:
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In the table to the right, list all family members who live in the same home as your child.	NAME	AGE	RELATION TO CHILD

Do you have any family pets? (List name and type)	
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PARENT 1 INFORMATION

FULL NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	EMAIL	
PHONE 2 <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	PREFERRED METHOD OF CONTACT	<input type="checkbox"/> PHONE 1 <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE 2 <input type="checkbox"/> TEXT
PLACE OF EMPLOYMENT	POSITION	

PARENT 2 INFORMATION

FULL NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	EMAIL	
PHONE 2 <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	PREFERRED METHOD OF CONTACT	<input type="checkbox"/> PHONE 1 <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE 2 <input type="checkbox"/> TEXT
PLACE OF EMPLOYMENT	POSITION	

Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)	
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Are there any other languages spoken in the home? If yes, which language(s) and how often? Has your child ever lived in a country other than USA? If yes, for how long.	
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	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER
Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)		

CHILD'S HEALTH BACKGROUND			
Describe your pregnancy, including any complications.			
Describe your labor/delivery, including any complications.			
TYPE OF BIRTH (check all that apply) <input type="checkbox"/> Spontaneous (not induced) <input type="checkbox"/> Induced <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section			
BIRTH PLACE (hospital/birth center)		NICU <input type="checkbox"/> Yes <input type="checkbox"/> No How long?	
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	
Were there any complications after birth or during the first few weeks?	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty feeding <input type="checkbox"/> Birth defect <input type="checkbox"/> Jaundice <input type="checkbox"/> Seizures <input type="checkbox"/> Other:		
Has your child's hearing been tested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where?			<input type="checkbox"/> Passed <input type="checkbox"/> Did not pass
Describe any serious illnesses, injuries, or medical procedures your child has experienced.			
List any environmental or food allergies.			
List any routine medications your child is currently taking or has taken long term.			
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.			

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT	
At what age did your child begin:	<input type="checkbox"/> BABBLING (bababa) _____ months <input type="checkbox"/> JARGON (bada bama) _____ months <input type="checkbox"/> FIRST WORD _____ at _____ months <input type="checkbox"/> TWO-WORD COMBO (more milk) _____ months <input type="checkbox"/> THREE-WORD COMBO _____ months/years <input type="checkbox"/> SENTENCES _____ months/years <input type="checkbox"/> READING LETTERS _____ years <input type="checkbox"/> WRITING LETTERS _____ years <input type="checkbox"/> READING WORDS _____ years <input type="checkbox"/> WRITING WORDS _____ years <input type="checkbox"/> READING SENTENCES _____ years <input type="checkbox"/> WRITING SENTENCES _____ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	<input type="checkbox"/> Parent(s) <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Peers <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Extended Family <input type="checkbox"/> Strangers _____% _____% _____% _____% _____% _____%
Has your child's speech-language been evaluated before? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

CHILD'S STRENGTHS AND FAVORITES	
Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE TOYS	
FAVORITE MOVIES	
FAVORITE FOODS	
FAVORITE BOOKS	

<p>Please list anything else that you feel is important to know for the purposes of evaluating/providing services to your child</p>	
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Thank you for taking the time to complete this information about your child.

PRINT PARENT/GUARDIAN NAME

SIGNATURE

DATE