Speech-Language Therapy Intake Form

Child's Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____cell_____

Parent/Guardian's Name: _____

Telephone: _____ Cell: _____

E-Mail Address _____

Patient Diagnosis: _____

Referred by: _____

History:

Born prematurely? **YES**¦**NO**¦ How many weeks gestation? _____

Any complications during pregnancy? **YES**¦**NO**¦

If yes, please explain:

_____

_____

If applicable, please write when your child achieved the following milestone:

Attained head control: _____

Rolled over: _____

Crawled: _____

Walked: _____

Babbled: _____

1st words: _____

Current: Height_____ Weight_____

Cleft Palate: Yes or No

Allergies: _____

Seizures: Are they controlled and how? _____

Dates of past 2- 3 Seizures _____Type of Seizure: _____

Heart or Blood Pressure Issues: _____

Kidney/Liver Issues: _____G-Tube or Shunt: _____

Recent surgeries: _____

_____

_____

Medications/For: _____

Current Therapies: PT, OT, Speech, Hippo, Alternative, Etc.

_____

_____

_____

_____

Attends School: _____ Grade: _____

Wheelchair/Walker/Crutches/Walking Independently? _____

Communication: (single words, utterance length, how many words in vocabulary)

_____

_____

_____

_____

Behavior Issues:_____

Sitting: _____

Crawling: _____

Feeding Issues: _____

Sensory Issues: _____

Sleeping Issues: _____

History of Ear Infections: _____

Hearing Tested: Yes or No If yes, RESULTS: _____

Any sensitivity to noise: _____

Any fine-motor concerns: _____

Any gross-motor concerns: _____

What areas do you feel need to be addressed in speech-language therapy:

_____

_____

_____

_____

What achievements would you like to see your child attain?

_____

_____

Any additional comments/concerns:

_____

_____

_____

Your child's interests and favorite toys/activities:

_____

_____

_____

Please list the words that your child currently has in his/her vocabulary (please list even if they are word approximations):

Physician and Therapist Information and Consent for Release of Information

1. **Pediatrician or General Practice:** _____

Address_____

City: _____ State: _____ Zip: _____

Office Number: _____

Fax Number: _____

2. **School:** _____

Address _____

City: _____ State: _____ Zip: _____

Office Number: _____ Fax Number: _____

3. **Neurologist:** _____

Address _____

City: _____ State: _____ Zip: _____

Office Number: _____ Fax Number: _____

4. **Therapy Clinic for PT/OT/ST or ongoing Speech-Language Pathologist**:

_____

Address: _____

City: _____ State: _____ Zip: _____

Office Number: _____ Fax Number: _____

I give permission for information regarding _____'s speech and language therapy with Treehouse Pediatric Therapy, LLC to be released to the above providers, agencies and professionals.

_____ _____

Signature of Parent or Guardian Date

Mail to (or bring to your 1st appointment):)