



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, Wee Talk, LLC or Wee CommunicATE LLC to be released to the above providers, agencies and professionals.

Signature of Parent or Guardian
Mail to (or bring to your 1st appointment):)

Date