CASE HISTORY/INTAKE FORM

Please fill out this form to the best of your ability and return prior to your evaluation appointment. This information will give us a better understanding of your child and help out with the evaluation process. All information is strictly confidential.

Today's Date: _____

Person completing this form: _____

Description of problem/concern: _____

_____

When did you first notice the problem? _____

What information do you hope to gain from this evaluation? _____

_____

GENERAL INFORMATION

Child's Name: _____ Birthdate: _____ Sex: ❑ M ❑ F

Address: _____ Email: _____

_____

Mother's Name: _____ Phone Number: _____

Mother's Occupation: _____

Father's Name:_____ Phone Number: _____

Father's Occupation: _____

Language(s) spoken in the home: _____

Child lives with (check one):

❏ Birth Parents ❏ Foster Parents ❏ One Parent

❏ Adoptive Parents ❏ Parent and Step-Parent ❏ Other _____

Other Children in the family:

Name Age Sex Speech/Hearing Difficulties (if applicable)

_____

_____

_____

_____

**Referred by: _____

MEDICAL HISTORY

Doctor's name/Contact info: _____

Dentist/Orthodontist name/Contact info: _____

Has your child ever received speech therapy? ❏ Yes ❏ No

If yes; where and when? _____

What was he/she working on? _____

Has your child been seen by any specialists? ❏ Yes ❏ No

If yes; please list names, type of specialist, contact information, date seen, and results

_____

_____

_____

_____

_____

Please mark if your child has a diagnosis of any of the following conditions *(list dates or additional information if applicable):*

❑ Food Allergies: _____ ❑ Special Dietary Restrictions: _____

❑ Other Allergies: _____

❑ Ear Infections: _____ ❑ Frequent Colds (More than 6 per year): _____

❑ Frequent Headaches: _____❑ High Fever ❑ Seizures: _____

❑ Sinusitis: _____ ❑ Tonsillitis: _____ ❑ Asthma/breathing difficulties

❑ ADD/ADHD ❑ Autism Spectrum Disorder ❑ Vision Problems: _____

❑ Sleeping difficulties (if so, please explain): _____

List any medications your child takes regularly: _____

_____

_____

Has your child had any surgeries? *If yes, what type and when* _____

_____

_____

Please indicate the most recent date administered and results of the following:

Vision Test: _____

Hearing Test: _____

BIRTH/DEVELOPMENT HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.): ____

_____

_____

Please describe any complications during pregnancy/delivery: _____

_____

_____

Type of delivery: ❑ Vaginal ❑ Cesarean (if yes, reason): _____

Was your child born prematurely? ❑ No ❑ Yes (if yes, how early?): _____

Did/does your child have any difficulties with feeding? ❑ Yes ❑ No

If so, explain. _____

_____

How was your child fed? ❑ Bottle fed ❑ Breast fed

At what **approximate** age did your child:

_____ Ween from a bottle _____ Drink independently from an open cup

_____ Finger feed him/herself _____ Eat with a spoon/fork

Please list the **approximate** ages at which your child achieved the following developmental milestones:

_____ Crawled _____ Sat _____ Walked

_____ Fed self _____ Used the toilet _____ Babbled

_____ Used single words (e.g., mama, dada, dog, etc.)

_____ Combined words (e.g., daddy shoe, more milk, etc.)

_____ Engaged in conversation

SPEECH/LANGUAGE HISTORY

Please answer the questions below with as much detail as appropriate

How does your child primarily communicate? (gestures, single words, short phrases, conversation, etc.) _____

_____

Does your child respond to sound? (e.g., responds to all sounds, tolerate loud noises, cries/screams with loud noises, inconsistently responds to sounds, etc.)

_____

Does your child get frustrated by his/her difficulty or inability to communicate? _____

_____

If your child talks now, can you understand him/her? Can family members? Can strangers? _____

_____

Do you believe that your child stutters or stammers? _____

Does your child answer questions? _____

Does your child follow directions? _____

Does your child point to objects upon request? _____

*Please check any of the boxes of behavioral characteristics that are applicable to your child:

❑ Cooperative	❑ Attentive	❑ Restless
❑ Easily frustrated/impulsive	❑ Easily distracted	❑ Destructive
❑ Willing to try new activities	❑ Withdrawn	❑ Stubborn
❑ Inappropriate behavior	❑ Poor eye contact	❑ Self-abusive
❑ Separation difficulties	❑ Other: _____	

How does your child interact with others (e.g., shy, aggressive, inflexible, friendly, etc.)? _____

_____

_____

Do you have any concerns about your child's social skills or ability to make/keep friends?

Please describe. _____

_____

EDUCATIONAL HISTORY

Name of school/ grade: _____

Teacher's name: _____

Has your child repeated a grade? ❑ Yes ❑ No

Has his/her teacher reported any concerns to you? Please describe.

_____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving any intervention services? _____

_____

Is your child on an Individualized Education Plan (IEP) or 504 Plan? ❑ Yes ❑ No

If so, please explain what services or supports. _____

_____

OTHER INFORMATION

What kinds of activities does your child enjoy? _____

_____

_____

Does your child have any activities or foods he/she strongly dislikes? _____

_____

Please provide any additional information that might be helpful in evaluating your child.

_____

_____

_____

_____