Kalamazoo Speech Associates
Center for Myofunctional and Speech-Language Therapy

SPEECH-LANGUAGE EVALUATION INTAKE FORM

We thank you in advance for completing this form as accurately and thoroughly as possible.
The answers to these questions directly contribute to developing the proper treatment plan for your child.

CLIENT INFORMATION

Client Full Name: _____
Date of Birth: _____ Age: _____ Grade: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Referred By: _____
Doctor/Pediatrician: _____
Doctor/Pediatrician Address: _____
Phone Number: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian Name (1): _____
Employer Name & Address: _____
Preferred Phone Number: _____ ☐ Home ☐ Mobile
Secondary Phone Number: _____ ☐ Home ☐ Mobile
Email: _____

Parent/Guardian Name (2): _____
Employer Name & Address: _____
Preferred Phone Number: _____ ☐ Home ☐ Mobile
Secondary Phone Number: _____ ☐ Home ☐ Mobile
Email: _____

SIBLING INFORMATION (if applicable)

Full Name _____ Age _____
Full Name _____ Age _____
Full Name _____ Age _____
Full Name _____ Age _____

Please indicate if any siblings or parents have had a speech and/or hearing problem?

BIRTH HISTORY

Age of parent(s) at child's birth:
Parent 1: ____ Parent 2: ____

Pregnancy:
☐ Normal
☐ Difficulties
Specify Difficulties (if any):

Birth:
Weight: ____ lbs.
Length: ____ inches
Order of birth: ____
☐ Required Oxygen
☐ Jaundiced
☐ Light Treatment
☐ Other:

Labor & Delivery:
Length of Hard Labor: ____ hrs.
☐ Premature ____ # days
☐ No Complications
☐ Late ____ # days
☐ Instruments Used _____
☐ Caesarean Section
☐ Breech

Difficulties with:
☐ Health
☐ Feeding
☐ Sleeping
Please explain:

DEVELOPMENTAL HISTORY

Note the age at which the following took place:

Sitting alone ____ months
Walking alone ____ months
Creeping on all fours ____ months
Toilet trained: ☐ Day ☐Night

List any medical conditions that might have affected your child's speech/language development (e.g., seizures, meningitis, ear infections, heart trouble).

Please indicate if your child has experienced any of the following conditions:

☐ Ear infections (☐ frequent ☐occasional)
☐ Dental problems
☐ Vision problems
☐ Enlarged tonsils and/or adenoids
☐ Allergies, please specify type:
☐ Asthma

When was your child's hearing last evaluated/screened?

Date: _____ Location: _____

Recommendations: _____

Does your child take any medications (Please Specify)? _____

MEDICAL

☐ Adenoids _____ (Date)
☐ Tonsils _____ (Date)
☐ Pressure equalization (PE) tubes _____ (Date)
☐ Tongue-tie _____ (Date)
☐ Cleft lip/palate repair _____ (Date)
☐ Other: _____

Hospitalizations:

Serious Illnesses:

SPEECH/LANGUAGE HISTORY AND DEVELOPMENT

☐ Turned head toward noise _____ (date)
☐ Babbled _____ (date)
☐ Said single words _____ (date)
☐ Combined two words together _____ (date)

Check all that apply to your child:

☐ Seems to be delayed in learning to talk.
☐ Does not seem to try to communicate.
☐ Uses at least three-to-four-word sentences.
☐ Understands you as well as he/she should.
☐ Echoes what you and other people say.
☐ Sometimes communicates with sounds/words.
☐ Communicates primarily with gestures.
☐ Uses complete sentences.
☐ Repeats sounds/words frequently.
☐ Follows one-part directions (e.g., "Give me the book.")
☐ Follows two-part directions (e.g., "Get your pajamas and bring them to the bathroom.")

If your child talks in sentences, are they complete and correct (e.g., "The dog is big," "Mommy is cooking," "She sits on the chair.") or are they incomplete (e.g., "Dog big," "Mommy cooking," "Her sit on the chair.")? Give examples:

Who understands your child most of the time?

☐ Parents ☐ Brothers/Sisters ☐ Relatives ☐ Strangers ☐ Playmates

How often do you understand your child's speech? (estimated percentage) ____ %

Have you noticed that your child:

☐ Doesn't speak clearly? ☐ Leaves off parts of words? ☐ Becomes frustrated when not understood?
☐ Consistently has a hoarse voice? ☐ Has difficulty getting his/her needs met at home?
☐ Has problems eating (sucking, swallowing, chewing, drooling, gagging, choking, coughing, etc.)?

Has your child had previous speech-language therapy? ☐ Yes ☐ No

If yes, where/from whom? _____

Dates of previous therapy: _____

Does your child currently receive speech-language therapy services? ☐ Yes ☐ No

If yes, where/from whom? _____

Dates of concurrent therapy: _____

BEHAVIOR/PLAY CHARACTERISTICS

☐ No specific problems ☐ Easily frustrated ☐ Difficult to discipline

☐ Plays well with other children ☐ Fights frequently with playmates

Does your child:

☐ Play well alone? ☐ Prefer to play alone? ☐ Pretend during play?

☐ Prefer to be a follower? ☐ Prefer to be a leader?

☐ Look at your face while communicating verbally or non-verbally?

☐ Play activities for a period of five minutes or longer without distraction?

☐ Have a favorite playmate? _____

☐ Have a favorite play activity or hobby? _____

What school does your child attend? _____ Grade: ____

Is your child's performance at school:

☐ Average ☐ Below average ☐ Above average

In what subject(s) does your child excel? _____

What subject(s) are difficult for your child? _____

Has your child ever skipped a grade or been held back? ☐ Yes ☐ No

Please describe any special education services (including speech therapy) your child has received at school:

Please note any specific concerns you have regarding your child's current performance at school

What other school(s) has your child attended? _____

ADDITIONAL INFORMATION

Please describe your child's speech-language problem in your own words:

Please give examples of the types of words and/or sentences your child uses:

How does your child let you know he/she wants a snack?

Does your child use signs/gestures to communicate (included invented signs)?

Other comments:

What are your expectations from us?