Communicate
Therapy Services, LLC

Client intake form

Name: _____ Date of Birth: _____

Person Completing This Form: _____

Relationship to Client: _____

Native language of child _____

Languages spoken in the home _____

Who referred you for the evaluation? _____

Other children in the family

Name	Age	Sex	Grade in School	Speech/language delays

Does anyone else in the family have speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please describe: _____

Has the child had any previous testing or therapy for speech, language, or hearing problems?
☐ Yes ☐ No

If yes, name of agency and date tested _____

What was he/she working on?: _____

(Please request that copies of all test results be sent to our office)

Medical diagnosis: _____

What are your speech/language concerns?

What are your goals for therapy?

When did you first become concerned with his/her speech and/or language skills?

Does your child become frustrated when they are not understood? ☐ Yes ☐ No

How much of your child's speech do you understand? ☐ 100% ☐ 75% ☐ 50% ☐ less than 25%

How much of your child's speech do others understand? ☐ 100% ☐ 75% ☐ 50% ☐ less than 25%

Please select the statement that best describes how your child communicates: ☐ gestures/pointing ☐ sounds ☐ single words ☐ 2-3 word sentences ☐ 4-5 word sentences ☐ 5+ word sentences

Other:

MEDICAL HISTORY

Weight of child at birth Was the child full term? ☐ Yes ☐ No

Were there any complications during the pregnancy or delivery? ☐ Yes ☐ No

If yes, please describe:

Has your child had or been diagnosed with any of the following (please check all that apply):

☐ear infections (how many___) ☐ ear tubes ☐ asthma ☐ hearing loss ☐ Thumb sucking

☐tonsillectomy/ adenoidectomy ☐ seizures ☐ allergies ☐ head injury ☐ vision problems

Has your child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

Has your child been hospitalized, had a serious accident or had an operation? ☐ Yes ☐ No
If yes, please explain:

Has the child had a hearing screening/evaluation? ☐ Yes ☐ No

When and results: _____

Do you currently have hearing concerns? _____

Has the child had a vision assessment? ☐ Yes ☐ No

When and results: _____

Do you currently have any vision concerns? _____

DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, and digestive upsets)? ☐ Yes ☐ No

If yes, please describe: _____

Give ages of development for the following behaviors:

Sat alone	_____	babbled	_____
crawled	_____	said first word	_____
walked	_____	put two words together	_____
potty trained	_____	spoke in 3 short sentences	_____

Does your child follow simple directions? ☐ Yes ☐ No

Does your child answer questions (who, what, when, where, why, how) ☐ Yes ☐ No

Does your child ask questions? ☐ Yes ☐ No

Does your child play with other children? ☐ Yes ☐ No

EDUCATION HISTORY

Current School _____

Grade: _____ Teacher: _____

Does your child have an Individual Education Plan (IEP) ☐ Yes ☐ No

What do you see as your child's strengths? _____

What do you see as your child's challenges? _____