



"Unlocking Your Child's Journey to Independence"™

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### INTAKE FORM Speech/Language Evaluations & Therapy

Child's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

D.O.B.: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_  
Referred By: \_\_\_\_\_

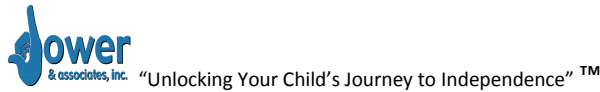
Phone: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

#### **Background and Related Information**

Do any family members have a history of speech, language, reading or learning difficulty?  
Please describe and list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



\* Speech/Language Evaluations and Therapy \* Academic & Remedial Tutoring \* Educational Consultations \* IEP Development & Consultations \*  
\* Autism Home/School Programs- Specialty: Applied Behavior Analysis (ABA) with Verbal Behavior Emphasis \*

Describe your child's speech, language, reading or learning problem.

How does your child usually communicate? (pointing, sentences, poor grammar, difficult to understand, etc.)

When was this problem first noticed? Has the problem worsened? Can you tell the cause of the problem?

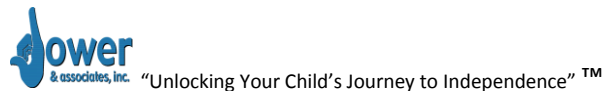
Is your child aware of the problem? Is he or she frustrated? Does he or she want to be helped?

Has your child been seen by any other specialists (physician, psychologist, therapist)? If so, when and what were your conclusions? (Please provide copies of reports.)

### **Birth and Developmental History**

What was your condition of your mother's pregnancy, labor and delivery? Were there any complications at birth?

Did your child reach normal developmental milestones within the average range? (sitting, crawling, eating, sleeping, talking)



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**Speech-Language Intake Form**  
**Updated March 2008**

When did your child begin talking? When did he or she put words together?

Has your child had difficulty learning to read?

Does your child have difficulty with functioning in the classroom, or with particular subjects?

What has your child's health condition been? (Allergies, frequent colds, ear infections, etc.)  
Has treatment of health problems been successful?

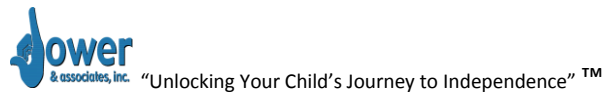
Is your child taking any medications?

Please provide any additional information that might be helpful to your evaluation or remediation of your child's problem.

Person Completing your Form: \_\_\_\_\_

Relationship to your Child: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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