Case History Intake Form

Patient Name: ____

Date of Birth: ______________________ Gender: _________________

Parent(s)/Guardian(s) Name: ____________________________________

Address: ____

Phone: __________________________ Email: ____________________

In the event you are unable to be reached, please provide an emergency contact name and phone number. _______________________________

____

Home Language: ____

Is your child exposed to any other languages? _____________________

____

Medical History

Please describe pregnancy and birth history. Include length of pregnancy, weight at delivery, and any complications prior, during, and following birth.

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List any formal, medical diagnoses: ______________________________

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Pediatrician’s Name: ____

Is your child being cared for by any additional medical specialists? If so, please provide the doctor's name and reason for care. _________________

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Does your child have a history of ear infections? If so, describe approximate number of infections and treatments. _____________________

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Has your child’s hearing been screened within the past year? Describe the results. ____

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Has your child’s vision been screened within the past year? Describe the results. ____

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Is your child currently taking any daily medications. If so, please list the medications and reason for need. ____________________________________

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Does your child have any allergies? If so, please list. ___________________

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Does your child have any other precautions not described above? If so, please describe. ____

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Communication Skills Development:

Please describe your child's primary method of communication (ie. Sign language, gestures, single words, short phrases, conversations, augmentative device, picture exchange). ______________________________

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If your child has met these milestones, please provide approximate age of occurrence.

Babbling ____________________________________

First Word ___________________________________

2-3 Words Combined _________________________

How much of your child's speech do you understand? Please check one.

______ >15% _______ 25% _______ 50% ______ 75% ______100%

How much of your child's speech do strangers understand? Select one.

______ >15% _______ 25% _______ 50% ______ 75% ______100%

Has your child received speech therapy previously? If so, please provide length of treatment (ie. ages 3-4) and reason for treatment. ______________

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Has your child received any additional therapy services? If so, please describe. ____

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Does your child attend preschool or school? If so, please provide the school name, grade, and frequency (ie. 5 days weekly, half-days). ________

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Please indicate your areas of concern with regard to your child's communication related abilities. Check all areas that apply.

Clarity of Speech		Non-Verbal	
Using Words to Express Needs/Wants		Eye Contact	
Understanding Words		Social Interaction	
Play Skills		Drooling	
Fluency/Stuttering		Repeats Heard Language (Echolalia)	
Following Directions		Maintaining a Topic of Conversation	
Written Language (Spelling, Content)		Answering Questions	
Sharing/Turn-Taking		Organization of Spoken Language	

Provide additional areas of concern if needed: ________________________

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