Sports Rehab Professional Therapy Associates

Speech and Language Intake
Pediatric

Today's Date:

Name: _____ Date of Birth: _____

Address: _____

E-Mail: _____

Phone: _____ Phone2: _____

Parent/Guardian Names: _____

Child lives with both parents? Yes☐ No☐ Primary language spoken in home: _____

Pediatrician: _____ Phone: _____

Referral Source: _____

Previous evaluations (list): _____

Therapy to date (list): _____

Describe present problem: _____

_____

_____

Who noted present problem? _____ When? _____

What is your child's reaction to the problem? _____

_____

How does the family react to the problem? _____

_____

Has there been any significant change in last six months? _____

If so, what? _____

How well is your child understood by: (i.e., what percentage of the time)

Mom: _____ Dad: _____ Younger siblings: _____ Older siblings: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

Describe what it is like to have a conversation with your child: _____

_____

_____

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PRENATAL/BIRTH HISTORY

Full Term: Yes☐ No☐ If no, how many weeks? _____

Birth Hospital: _____

Illnesses or accidents during pregnancy: _____

Use of alcohol, tobacco or medications during pregnancy: _____

Birth weight: _____Delivery: ☐ Vaginal ☐Cesarean ☐ Breech ☐ Feet First

Other unusual conditions that may have affected pregnancy or birth? _____

_____

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

☐ Seizures	☐ High fevers	☐ Measles	☐ Mumps
☐ Chicken pox	☐ Whooping cough	☐ Diphtheria	☐ Croup
☐ Pneumonia	☐ Tonsillitis	☐ Meningitis	☐ Encephalitis
☐ Rheumatic fever	☐ Tuberculosis	☐ Sinusitis	☐ Chronic colds
☐ Enlarged glands	☐ Thyroid	☐ Asthma	☐ Heart trouble

Explain any checked items here: _____

Are immunizations current? _____Current general health: _____

**Has your child had any earaches/ear infections? ☐Y ☐ N Please explain here: _____

_____

Allergies? (Describe) _____

Any other serious or recurrent illnesses? _____

Any operations? _____

Any accidents? _____

Any medications? (Past) _____ (Current) _____

Vision problems? _____Treatment:_____

Hearing difficulties: _____Treatment:_____

Dental problems? _____Treatment: _____

Other Medical History: _____

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DEVELOPMENTAL HISTORY

Age when child: *(If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)*

sat up alone _____ crawled _____ walked _____ toilet trained _____ dressed self_____

tied shoes _____ fed self independently _____ Weaned from bottle/breast _____

Is the child left or right handed? _____ Able to use: open cup☐ spoon ☐ straw☐

Any difficulty? (Y/N) Swallowing:_____ Chewing:_____ Drinking:_____

Blowing:_____ Drooling:_____ Food allergies: _____

Favorite Foods:_____

Aversive Foods (if any)_____

Attention span-for self-directed activities:_____ Adult-directed:_____

Eating and sleeping patterns:_____

Does your child respond typically to: Light? _____ Sound? _____ People? _____

Does your child: Play with others? _____ Who?_____

Eat and sleep well? _____ Cry appropriately ?_____ Laugh?_____ Smile? _____

Make wants/needs known? _____ How? _____

Does your child show unusual behavior (explain)? _____

_____

LANGUAGE DEVELOPMENT

Age when your child spoke first word:_____ combined words:_____ spoke in sentences:_____

What was your child's first word(s)?_____ first sentence?_____

Which sounds (if any) are incorrect?_____

How many words can your child say? (list if fewer than fifteen)_____

_____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (describe) _____

Does your child have difficulty following directions? (describe) _____

Any speech or hearing problems in the immediate or extended family (explain)?_____

_____

_____

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SOCIAL DEVELOPMENT

Names and ages of siblings: _____

Other adults living in the home: _____

Moves prior to age 10: _____

Relationship with peers: _____

Number of regular playmates: _____ Ages: _____ Genders: _____

Activities shared with parents and siblings: _____

How does your child handle frustration: _____

conflict: _____ separation: _____

Regular responsibilities: _____

Favorite places: _____ people: _____ toys: _____

snacks: _____ activities: _____ TV programs: _____

What motivates your child most? _____

What discipline methods work best? _____

SCHOOL HISTORY

Child's Current School and Grade: _____

Child's performance educationally: _____

Receiving special services at school: _____

How does your child's teacher describe his/her performance? _____

_____

Has the teacher expressed any concern? If so, what? _____

OTHER

What do you hope to have happen as a result of this evaluation? _____

Does the report need to be sent to specific agencies? _____ Where? _____

_____

Anything else you would like us to know? _____

_____

_____