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CLIENT INTAKE FORM

SPEECH - LANGUAGE THERAPY

FORM COMPLETED BY: DATE:

RELATIONSHIP TO CLIENT: PHONE #:

EMAIL: ADDRESS:

PREFERRED MODE OF CONTACT - CALL: TEXT: EMAIL:

PERSONAL INFORMATION (CLIENT)

FIRST NAME: LAST NAME:

MALE: FEMALE:

D.O.B.:

ADDRESS (CHECK IF SAME AS ABOVE) :

HOBBIES/INTERESTS:

HOME SETTING

PARENT/CAREGIVER (1): RELATIONSHIP:

EMAIL: PHONE #:

OCCUPATION:

PARENT/CAREGIVER (2): RELATIONSHIP:

EMAIL: PHONE #:

OCCUPATION:

PRIMARY LANGUAGE(S) SPOKEN IN THE HOME:

WITH WHOM DOES THE CLIENT LIVE? PLEASE INDICATE RELATION:

MEDICAL & DEVELOPMENTAL HISTORY

PLEASE LIST ANY MEDICAL DIAGNOSES (INCLUDE DATES):

WERE THERE ANY PROBLEMS DURING PREGNANCY/BIRTH? YES*: NO:

*IF YES TO ABOVE OR UNKNOWN, PLEASE EXPLAIN:

HAS THE CLIENT EXPERIENCED ANY HEARING PROBLEMS? YES*: NO:

*IF YES TO ABOVE, PLEASE EXPLAIN:

HOW OLD WAS THE CLIENT WHEN THEY BEGAN TO WALK?

HOW OLD WAS THE CLIENT WHEN THEY SPOKE THEIR FIRST WORDS?

HOW OLD WAS THE CLIENT WHEN THEY BEGAN TO EAT SOLID FOODS?

PLEASE LIST ANY MEDICATIONS, VITAMINS, AND/OR SUPPLEMENTS THE CLIENT IS CURRENTLY TAKING:

PLEASE LIST ANY ALLERGIES THE CLIENT HAS:

IF THE CLIENT HAS HAD ANY OF THE FOLLOWING, PLEASE CHECK BELOW*:

EARLY INTERVENTION		PHYSICAL THERAPY		COUNSELING	
OCCUPATIONAL THERAPY		BEHAVIORAL THERAPY		TUBES IN EARS	
VISUAL IMPAIRMENT		SENSORY PROBLEMS		OTHER	

*IF CHECKED ABOVE, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY SERIOUS ACCIDENTS, SURGERIES AND/OR ILLNESSES:

EDUCATIONAL HISTORY

SCHOOLS/ACADEMIC PROGRAMS ATTENDED (PLEASE INCLUDE DURATION):

CURRENT ACADEMIC GRADE/LEVEL:

DOES THE CLIENT READ? YES: ☐ NO: ☐ WRITE? YES: ☐ NO: ☐

THE CLIENT HAD/HAS AN IFSP, IEP, OR 504 PLAN: YES*: ☐ NO: ☐

*IF YES TO ABOVE, PLEASE EXPLAIN ANY ACCOMMODATIONS (IF APPLICABLE):

HAS THE CLIENT RECEIVED SKILLED SERVICES IN THEIR SCHOOL/PROGRAM (E.G., SPEECH/OCCUPATIONAL THERAPY) YES*: ☐ NO: ☐

*IF YES TO ABOVE, PLEASE EXPLAIN TYPE AND DURATION OF SERVICE:

WHAT IS THE CLIENT'S FAVORITE SUBJECT/TASK?

WHAT IS THE CLIENT'S *LEAST* FAVORITE SUBJECT/TASK?

DO YOU HAVE ANY CONCERNS ABOUT THE CLIENT'S ACADEMIC PERFORMANCE? IF SO, PLEASE EXPLAIN:

SPEECH AND LANGUAGE

PLEASE SELECT THE CLIENT'S PRIMARY MODE(S) OF COMMUNICATION:

VERBAL LANGUAGE	☐	SOME WORDS	☐	VOCALIZATIONS	☐
MANUAL SIGNS/ASL	☐	GESTURES	☐	PHYSICAL DIRECTING	☐
AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC)	☐	OTHER: *PLEASE DESCRIBE			

SPEECH AND LANGUAGE (CONTINUED)

IS THE CLIENT USUALLY UNDERSTOOD BY UNFAMILIAR INDIVIDUALS? YES: ☐ NO: ☐ SOMETIMES: ☐

DOES THE CLIENT APPEAR FRUSTRATED BY THEIR COMMUNICATION? YES: ☐ NO: ☐ SOMETIMES: ☐

PLEASE SELECT THE FOLLOWING THAT APPLY TO THE CLIENT - DO THEY:

MAKE REQUESTS FOR ITEMS	YES: ☐	NO: ☐	ASK QUESTIONS	YES: ☐	NO: ☐
ASK FOR HELP	YES: ☐	NO: ☐	MAKE COMMENTS	YES: ☐	NO: ☐
INITIATE INTERACTIONS	YES: ☐	NO: ☐	STAY ON THE TOPIC OF CONVERSATION	YES: ☐	NO: ☐
INVITE OTHERS TO PLAY/JOIN GROUP	YES: ☐	NO: ☐	TAKE TURNS	YES: ☐	NO: ☐

PLEASE PROVIDE ANY ADDITIONAL DETAIL ABOUT THE WAY THE CLIENT COMMUNICATES/INTERACTS WITH OTHERS:

IS THE CLIENT CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED SPEECH THERAPY SERVICES? YES*: ☐ NO: ☐

*IF YES TO ABOVE, PLEASE EXPLAIN WHAT THEY WERE WORKING ON AND DURATION OF SERVICE:

PLEASE DESCRIBE THE CLIENT'S STRENGTHS:

PLEASE DESCRIBE ANY PRESENT CONCERNS:

PLEASE DESCRIBE THE GOALS YOU HAVE FOR THE CLIENT. WHAT WOULD YOU LIKE TO SEE THEM WORK ON?

ADDITIONAL COMMENTS

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT WOULD BE PERTINENT TO WORKING WITH THE CLIENT AND FAMILY:

-THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM-