



Beyond Speech Therapy, LLC  
1101 McMurtrie Dr., Suite G1, Huntsville, AL 35806  
office@mtwspeechtherapy.com

## Child Intake Form / History

Client Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Diagnosis (if known): \_\_\_\_\_  
Parent(s) / Guardians: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #1: \_\_\_\_\_  Cell  Home  Work  Other  
Phone #2: \_\_\_\_\_  Cell  Home  Work  Other  
Email #1: \_\_\_\_\_ Email #2: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_  
Emergency Contact Relationship to Child: \_\_\_\_\_  
Emergency Contact (Information): \_\_\_\_\_

Client's Physician: \_\_\_\_\_  
Physician Phone Number: \_\_\_\_\_  
Physician Address: \_\_\_\_\_

Other Physicians / Specialists Involved In Care:  
Referring Physician: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
Secondary Physician: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Physician Address: \_\_\_\_\_

How did you hear about Beyond Speech Therapy?

\_\_\_\_\_

### **Family Background**

Parent 1 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

What adults does the child live with? Check all that apply:

- Birth Parent(s)     Adoptive Parent(s)     Foster Parent(s)  
 Grandparent(s)     Both Parents     Parent 1 Only  
 Parent 2 Only     Other:

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____	Speech Issues: _____
Child 2 Name: _____	Speech Issues: _____
Child 3 Name: _____	Speech Issues: _____
Child 4 Name: _____	Speech Issues: _____
Child 5 Name: _____	Speech Issues: _____

Language(s) spoken in the home: \_\_\_\_\_

Who speaks the other language(s)? \_\_\_\_\_

Describe the child's use/understanding of the spoken language(s): \_\_\_\_\_

Is there anything additional you would like to share about the family / home environment? \_\_\_\_\_

### **Evaluation**

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: \_\_\_\_\_

What are you expecting out of this evaluation / meeting? \_\_\_\_\_

Has the child had a previous speech, language or feeding evaluation / treatment?

Yes  No    By whom: \_\_\_\_\_ When: \_\_\_\_\_

Describe the results: \_\_\_\_\_

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: \_\_\_\_\_

---

---

---

---

At what age did you first notice the problem? \_\_\_\_\_

How do the child's communication difficulties impact the family? \_\_\_\_\_

---

---

If anyone else in the family has a speech or language diagnosis, please describe it: \_\_\_\_\_

---

Is the child aware of or frustrated by their communication difficulties? \_\_\_\_\_

---

---

### **Medical History**

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

---

---

---

---

---

---

---

---

---

---

### *Mother's Health During Pregnancy:*

1. Were there any infections or illnesses?  Yes  No

Describe: \_\_\_\_\_

2. Was there any stress during the pregnancy?  Yes  No

Describe: \_\_\_\_\_

3. Were there any complications during labor or delivery?  Yes  No

Describe: \_\_\_\_\_

4. What was the mother's age at the time of delivery? \_\_\_\_\_ years

### *Child's Health:*

1. How many weeks gestation was the child born? \_\_\_ weeks (40 weeks is typical)

2. The child was \_\_\_\_\_ lbs \_\_\_\_\_ oz and \_\_\_\_\_ inches at birth
3. How was the child delivered?  Vaginally  Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

---

---

---

*Check and describe all that apply:*

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> Adenoidectomy          | Describe: _____ |
| <input type="checkbox"/> Asthma                 | Describe: _____ |
| <input type="checkbox"/> Behavior Issues        | Describe: _____ |
| <input type="checkbox"/> Brain injury           | Describe: _____ |
| <input type="checkbox"/> Breathing problems     | Describe: _____ |
| <input type="checkbox"/> Cardiac issues         | Describe: _____ |
| <input type="checkbox"/> Chicken pox            | Describe: _____ |
| <input type="checkbox"/> Diabetes               | Describe: _____ |
| <input type="checkbox"/> Ear infections         | Describe: _____ |
| <input type="checkbox"/> Ear tubes              | Describe: _____ |
| <input type="checkbox"/> Encephalitis           | Describe: _____ |
| <input type="checkbox"/> Frequent colds         | Describe: _____ |
| <input type="checkbox"/> High fever             | Describe: _____ |
| <input type="checkbox"/> Measles                | Describe: _____ |
| <input type="checkbox"/> Meningitis             | Describe: _____ |
| <input type="checkbox"/> Mumps                  | Describe: _____ |
| <input type="checkbox"/> Seizures               | Describe: _____ |
| <input type="checkbox"/> Sensory issues         | Describe: _____ |
| <input type="checkbox"/> Sleep issues           | Describe: _____ |
| <input type="checkbox"/> Tongue tie/or lip tie  | Describe: _____ |
| <input type="checkbox"/> Tonsillitis            | Describe: _____ |
| <input type="checkbox"/> Tonsillectomy          | Describe: _____ |
| <input type="checkbox"/> Traumatic brain injury | Describe: _____ |
| <input type="checkbox"/> Vision issues          | Describe: _____ |

Is the child up to date with immunizations:  Yes  No

Please describe: \_\_\_\_\_

---

---

Has the child ever had surgery?  Yes  No

Please describe: \_\_\_\_\_

---

---

Has the child ever been hospitalized:  Yes  No

Please describe: \_\_\_\_\_

---

Has the child ever been in a serious accident?  Yes  No

Please describe: \_\_\_\_\_

---

Does the child have a chronic illness? If so, please describe: \_\_\_\_\_

---

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: \_\_\_\_\_

Medication 2: \_\_\_\_\_

Medication 3: \_\_\_\_\_

Medication 4: \_\_\_\_\_

---

Does the child have any known allergies?  Yes  No

Describe: \_\_\_\_\_

---

Does the child currently use any equipment? (communication device, walker, etc.) Describe: \_\_\_\_\_

---

Does the child have a history of ear infections, tubes, etc. or use hearing aides?

Yes  No

Describe: \_\_\_\_\_

---

Does the child have any known hearing loss?  Yes  No

Describe: \_\_\_\_\_

If you have any concerns about the child's hearing, please describe: \_\_\_\_\_

\_\_\_\_\_

Describe the child's current health status: \_\_\_\_\_

\_\_\_\_\_

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

Developmental Pediatrician \_\_\_\_\_

Neurologist \_\_\_\_\_

PT \_\_\_\_\_

OT \_\_\_\_\_

SLP \_\_\_\_\_

Behavioral Therapist \_\_\_\_\_

Educational Consultant \_\_\_\_\_

Psychologist / Psychiatrist \_\_\_\_\_

Vision Therapist \_\_\_\_\_

Other: \_\_\_\_\_

### **Developmental History**

*At what age did the child do the following:*

Sit alone: \_\_\_\_\_ Crawl: \_\_\_\_\_

Stood Up: \_\_\_\_\_ Walk: \_\_\_\_\_

Made Sounds: \_\_\_\_\_ First Word: \_\_\_\_\_

Combined Words: \_\_\_\_\_ Sentences: \_\_\_\_\_

Fed Self: \_\_\_\_\_ Understood by Others \_\_\_\_\_

Toilet Trained: \_\_\_\_\_ Dressed Self: \_\_\_\_\_

*Does the child do any of the following:*

Choke on liquids  Choke on foods

Avoid foods  Gag on foods

Maintain a special diet  Use a pacifier / suck thumb

Mouth objects  Grind teeth

Snore  Drool

Please describe any of the above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was your child breastfed or bottle-fed? \_\_\_\_\_  
Were there any complications with sucking or latching?  
\_\_\_\_\_

Has your child been weaned from breastfeeding/bottle-feeding?  Yes  No  
At what age? \_\_\_\_\_

What type of cup does your child use? (bottle, sippy cup, spout cup, straw cup, open cup, etc.) \_\_\_\_\_

Describe your child's independence level at mealtimes. ( feeds self with utensils, feeds self with fingers, fed by caregiver, etc.)  
\_\_\_\_\_

If under 4 years of age, how many words does the child say:  
 0-20  21-50  51-100  101-150  151-300  301-500  
 501+

Does the child produce sentences of the following length:  
 2 words  3 words  4 words  5+ words

What percentage of the child's speech do you understand? \_\_\_\_\_%  
How well do people outside of the family understand their speech? \_\_\_\_\_%

If the child is not using words, how do they communicate? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Does the child have any difficulty with the following:*

- |   |  |
|---|--|
| <input type="checkbox"/> Attention                  | <input type="checkbox"/> Frustration Tolerance   |
| <input type="checkbox"/> Aggression                 | <input type="checkbox"/> Anger                   |
| <input type="checkbox"/> Answering simple questions | <input type="checkbox"/> Answering –WH questions |
| <input type="checkbox"/> Understanding people       | <input type="checkbox"/> Following directions    |
| <input type="checkbox"/> Excessive drooling         | <input type="checkbox"/> Chewing or eating       |
| <input type="checkbox"/> Producing speech sounds    | <input type="checkbox"/> Stuttering              |
| <input type="checkbox"/> Reading                    | <input type="checkbox"/> School work             |
| <input type="checkbox"/> Remembering                | <input type="checkbox"/> Maintaining eye contact |
| <input type="checkbox"/> Transitions                | <input type="checkbox"/> Word Retrieval          |

Other difficulties: \_\_\_\_\_  
Please describe any of the above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: \_\_\_\_\_

---

---

**Education**

Is the child currently enrolled in daycare/ school:  Yes  No

What is the name of the program? \_\_\_\_\_

What day(s) do they attend? \_\_\_\_\_

What is their grade level: \_\_\_\_\_

Type of classroom: \_\_\_\_\_

If they receive any accommodations, please describe: \_\_\_\_\_

Please describe any educational difficulties or learning challenges that this child has faced: \_\_\_\_\_

**Social History**

Describe how the child interacts with parents, siblings, or other family members:

Please describe the communication difficulties the child faces in the home environment: \_\_\_\_\_

Describe any significant events or changes within the home: \_\_\_\_\_

What are the child's strengths? \_\_\_\_\_

What are the child's weaknesses? \_\_\_\_\_

What are the child's favorite activities? \_\_\_\_\_

---

---

---

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? \_\_\_\_\_

---

---

Does the child become easily frustrated with certain activities? If so, please explain: \_\_\_\_\_

---

---

Describe how the child interacts with other children: \_\_\_\_\_

---

---

What are your goals for the child over the next 6 months? \_\_\_\_\_

---

---

---

What are your goals for the child over the next 5 years? \_\_\_\_\_

---

---

---

Is there anything else that is important for us to know about the child?

---

---

---

---

---

Person filling out the form: \_\_\_\_\_

Relationship to the child: \_\_\_\_\_