

Ashleigh Hurd, CCC-SLP, LLC
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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 Ashleigh Hurd, CCC-SLP, LLC?

Family Background

Parent 1 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Parent 2 Name: _____ Age: _____
Occupation: _____ Education Level: _____
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: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 2 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 3 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 4 Name: _____ Age: ___ Sex: ___ Speech Issues: _____
Child 5 Name: _____ Age: ___ Sex: ___ Speech Issues: _____

Language(s) spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the 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:

- Adenoidectomy Describe: _____
- Asthma Describe: _____
- Behavior Issues Describe: _____
- Brain injury Describe: _____
- Breathing problems Describe: _____
- Cardiac issues Describe: _____
- Chicken pox Describe: _____
- Diabetes Describe: _____
- Ear infections Describe: _____
- Ear tubes Describe: _____
- Encephalitis Describe: _____
- Frequent colds Describe: _____
- High fever Describe: _____
- Measles Describe: _____
- Meningitis Describe: _____
- Mumps Describe: _____
- Seizures Describe: _____
- Sensory issues Describe: _____
- Sleep issues Describe: _____
- Tongue tie Describe: _____
- Tonsillitis Describe: _____
- Tonsillectomy Describe: _____
- Traumatic brain injury Describe: _____
- 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 Maintain a special diet

Use a pacifier / suck thumb Mouth objects

Please describe any of the above: _____

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:

Attention

Frustration Tolerance

Aggression

Anger

Answering simple questions

Answering –wh questions

Understanding people

Following directions

Excessive drooling

Chewing or eating

Producing speech sounds

Stuttering

Reading

School work

Remembering

Maintaining eye contact

Transitions

Word Retrieval

Other difficulties: _____

Please describe any of the above: _____

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

Educational History

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: _____