Client Intake Form		
Child's Name:	Date of Birth: Age: ____ yrs ____ mos. Gender: F M	Grade: School:
Parent/Guardian Name:	Email:	Cell: Work:
Parent/Guardian Name:	Email:	Cell: Work:
Mailing Address:		Home Phone:

Please check areas of concern:

☐ Speech

☐ Language (receptive & expressive)

☐ Literacy (reading & writing)

Previous Evaluations			
Discipline (OT, PT, Speech/Lang., Psych.)	Date	Name of Clinician	Results/Diagnosis

Today's Date:_____

Child Case History

A. Pregnancy & Delivery

Date of Birth	Birth Weight	Current Weight
Length of Pregnancy	Birth was **(circle):** Normal Caesarean Breech Multiple Birth	At birth was your child (circle): Jaundiced Cyanotic Blue
Was your child in the Neonatal Intensive Care Unit (NICU)? If so, why and for how long?	Were there any other complications during the pregnancy or delivery?	
Were there any feeding or swallowing problems at birth? Are there any feeding or swallowing concerns at this time?		

B. Motor Developmental Milestone

To the best of your knowledge, please list the age that the child:

Sat Unsupported _____ Crawled_____ Walked_____

Fed Self_____ Toilet-trained_____

Compared to other children your child's age, describe how he or she is able to sit, stand, run, and use his or her hands:

Today's Date:_____

C. Speech & Language Developmental Milestone

To the best of your knowledge, please list the age that the child:

Babbled _____ Used First Word_____ Put Words Together_____

How does your child currently communicate? For example, do they use gestures, single words, phrases, or complete sentences?

Does your child have difficulty making any particular speech sounds? Yes ____ No ____

If so, which ones?_____

Do others, outside your family, have trouble understanding your child? Yes ____ No ____

Does your child seem to be aware of speaking differently from others? Yes ____ No ____

If so, describe:

How does your child's voice sound?

Normal _____ Low-pitched_____ High-pitched_____

Hoarse _____ Nasal _____ Strained _____

Does your child display difficulties with fluency? For example, repeating sounds or words, or blocking mid-sentence? Does your child exhibit physical behaviors related to stuttering?

Please check any of the social communication skills your child may have difficulty with:

Eye Contact _____ Farewells/Greetings _____ Topic Maintenance_____

Understanding/Expressing Facial Expressions _____ Flexible-Thinking _____

Shared-attention _____ Other: _____

Today's Date:_____

D. Educational History

What school is your child currently enrolled in? _____

Grade?_____

Does your child have an Individualized Education Plan (IEP) for school-based services?

Yes _____ No _____

If yes, what services are provided on the IEP?

Has your child ever received special help or been in a special class in school?

Yes _____ No _____

If yes, explain briefly.

What motivates your child to engage in academics?

Which language & literacy skills does your child need support and/or remediation in? Check **ALL** that apply.

Language		Literacy	
Listening Comprehension		Phonemic Awareness	
Receptive Vocabulary		Phonological Awareness	
Following Directions		Decoding	
Linguistic Concepts		Sight Words	
Retrieval		Spelling	
Grammar		Reading Comprehension	
Organization		Fluency	
Expressive Vocabulary		Vocabulary	
Expressive Language		Written Expression	

Today's Date:_____

Does your child have any other diagnosis? Please list any allergies/medical diagnosis:

Office Use Only	
Billing Codes	Payment Method
92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) **92523** Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); **with** evaluation of language comprehension and expression (eg, receptive and expressive language) **92507** Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	☐ cash ☐ check ☐ credit/debit ☐ Paypal, Venmo, Cashapp and/or Zelle

Today's Date:_____