Child Intake Form

Please complete this application with a copy or picture of the front and back of your insurance card. Then mail, fax, scan, email or deliver to Keys To Communication.

Please attach any previous reports from school, therapists, or doctors.

Today's Date _____
Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female Primary Language:_____
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 *Keys to Communication*?
_____

Person filling out the form: _____
Relationship to the child: _____

Insurance

Insurance Group: _____
Subscriber's Name: _____
Subscriber's DOB: _____
Insured Identification: _____
Group Name: _____
Group Number: _____

Family Background

Parent 1 Name: _____ Age: _____ Primary Language: _____
Occupation: _____ Education Level: _____

Parent 2 Name: _____ Age: _____ Primary Language: _____
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) ☐Parent 2 Only
☐Grandparent(s) ☐Both Parents ☐Parent 1 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:_____

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

Evaluation History

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

Has the child had a previous speech, language or feeding evaluation / treatment? ☐Yes ☐No
By whom: _____ When: _____

Describe the results:
_____
_____
_____

At what age did you first notice the problem? _____
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

When and what were the results of the last hearing screening?

Date: _____

☐Pass ☐Fail

When and what were the results of the last vision screening?

Date: _____

☐Pass ☐Fail

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

_____

_____

_____

Birth History

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 pregnancy or childbirth.

_____

_____

_____

Has the child ever had surgery, been hospitalized or had been in a serious accident or have a chronic illness? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

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

Medication 1: _____

Medication 2: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe:_____

_____

_____

Does the child have a history of ear infections, tubes, etc. or use hearing aids? ☐Yes ☐No

Describe:_____

_____

_____

Please indicate which devices the child uses: ☐Glasses ☐Hearing aids ☐ Braces/Retainer ☐Other

Developmental History

At what age did the child do the following:

Sit alone:	Crawl:
Stand up:	Walk:
Make sounds:	First word:
Combine words:	Sentences:
Feed self:	Understood by others:
Toilet trained:	Dress 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:

_____
_____

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?

_____
_____
_____

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? _____

Have teachers mentioned concerns regarding speech, language, social skills, or education? If so, please explain:

_____
_____

Does the child receive special services at home or school? If so, which type and how often? (Please provide a copy of IFSP/IEP)

_____
_____

How does the child behave at school? Please describe if there are difficulties with specific subjects.

_____
_____

In any setting, how does the child behave when socializing with other children?

_____

_____

Social History

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

_____

_____

What are the child's strengths?

_____

_____

What are the child's weaknesses?

_____

_____

What are the child's favorite activities?

_____

_____

Describe how the child interacts with other children:

_____

_____

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

_____

_____

_____

SO THAT WE CAN BETTER SERVE YOU PLEASE BE SURE TO ATTACH ANY OF THE RECENT REPORTS SUCH AS:

- Doctor summaries
- Individual Family Service Plan (IFSP)
- Individual Education Plan (IEP)
- Dr Prescriptions
- Speech Reports
- Occupational Therapy Reports
- ABA reports