Intake Form

Please answer the following questions to better help me understand your child's needs.

Child's Name: ______________________________ DOB: ____________________
Age: _____________ Gender: ______________

- ❑ Please describe the nature of your concern. ____________________________
  ____
  ____
- ❑ Does your child have a medical diagnosis? ____ Yes ____ No If yes, explain.
  ____
  ____
- ❑ How would you rate your child's speech intelligibility? *Please circle one* *totally* intelligible, *most of the time* intelligible, *fairly* intelligible, or *not* intelligible.
- ❑ Has your child received previous therapy (OT, Speech, PT)?
  ____ Yes ____ No If yes, how long?____________________________________
  If yes, what were your child's goals? __________________________________
  ____
  ____
- ❑ Does your child have any known allergies? _____ Yes _____ No If so, please list: ____
- ❑ Has your child's hearing and vision been evaluated? If so, please indicate date and results: ____
- ❑ What would you like to see your child be able to do as a result of receiving speech therapy?____
  ____
  ____

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