Salubris Speech Therapy LLC

Child
Intake Form

DATE: _____

Child Information

FULL NAME: _____ DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER LIVES WITH: ☐ MOTHER ☐ FATHER ☐ GUARDIAN

LANGUAGE #1: _____ ☐ PREFERS LANGUAGE #2: _____ ☐ PREFERS

EMERGENCY CONTACT: _____ (NAME) _____ (RELATIONSHIP) _____ (PHONE)

Parent Information

PARENT 1: _____ PHONE: _____

HOME: _____ (STREET ADDRESS) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

EMAIL: _____ BEST CONTACT: ☐ PHONE ☐ TEXT ☐ EMAIL

PARENT 2: _____ PHONE: _____

HOME: _____ (STREET ADDRESS) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

EMAIL: _____ BEST CONTACT: ☐ PHONE ☐ TEXT ☐ EMAIL

Siblings at Home

NAME	AGE	GENDER	SPEECH/LANGUAGE DELAY?
		☐ MALE ☐ FEMALE	☐ YES ☐ NO
		☐ MALE ☐ FEMALE	☐ YES ☐ NO
		☐ MALE ☐ FEMALE	☐ YES ☐ NO
		☐ MALE ☐ FEMALE	☐ YES ☐ NO

Primary Care Physician

FULL NAME: _____ OFFICE PHONE: _____

OFFICE: _____ (STREET ADDRESS) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Insurance Information

Primary

INSURANCE COMPANY: _____ PLAN NAME: _____

POLICY #: _____ GROUP: _____ CONTACT: _____

Secondary

INSURANCE COMPANY: _____ PLAN NAME: _____

POLICY #: _____ GROUP: _____ CONTACT: _____

Medical History

Under a physician's care? ☐ NO ☐ YES, please explain: _____

Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check all that apply:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Colds often
- ☐ Cochlear implant(s)
- ☐ Diabetes
- ☐ Digestive difficulty
- ☐ Dyslexia
- ☐ Ear tubes
- ☐ Ear infections: How often? _____
- ☐ Encephalitis/Meningitis
- ☐ Flu: How often? _____
- ☐ High fevers
- ☐ Intellectual disability
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ PEG tube
- ☐ Poor appetite
- ☐ Seizures/convulsions
- ☐ Sensory integration disorder
- ☐ Sinusitis
- ☐ Sleeping difficulty
- ☐ Stuttering / cluttering
- ☐ Swallow difficulty
- ☐ Thumb/finger sucking
- ☐ Tonsillectomy
- ☐ Tracheostomy
- ☐ Traumatic brain injury:
  - ☐ Auto accident
  - ☐ Post-concussion
  - ☐ Other: _____
- ☐ Vocal fold pathology:
  - ☐ Hoarseness
  - ☐ Laryngectomy
  - ☐ Polyps / Nodules
  - ☐ Speech valve
  - ☐ Other: _____

Any other serious illness, injury, or surgery? _____

Birth History

Was there anything unusual about the pregnancy/birth? ☐ NO ☐ YES: _____

How many weeks was the pregnancy? ☐ < 28 ☐ 28-31 ☐ 32-36 ☐ 37-40+

Did the child go home with mother from the hospital? ☐ YES ☐ NO: _____

Developmental History

By what age did your child meet the following developmental milestones?

Sat alone: _____ Crawled: _____ Stood: _____ Walked: _____ Fed self: _____

Dressed self: _____ Toileted: _____ Single words: _____ Combined words: _____

Communication

Does your child have a speech problem? ☐ NO ☐ YES: _____

Does your child have a language problem? ☐ NO ☐ YES: _____

Previously evaluated? ☐ NO ☐ YES, when? _____ Results? _____

Did your child previously receive speech or language therapy? ☐ NO ☐ YES

If yes, when? _____ Results? _____

Does your child have a hearing problem? ☐ NO ☐ YES, describe: _____

Previously evaluated? ☐ NO ☐ YES When? _____ Results? _____

Does your child have a vision problem? ☐ NO ☐ YES, describe: _____

Does your child have a history of learning disability? ☐ NO ☐ YES: _____

What is your child's most difficult problem at home? _____

What is your child's most difficult problem at school? _____

Is your child frustrated with communication? ☐ NO ☐ YES, describe: _____

Salubris Speech Therapy 201 Hilda St Ste 23, Kissimmee, FL 34741 Office (407) 793-2795 Fax (321) 333-5682

Communication (continued)

Does your child:

Repeat sounds, words, or phrases over and over? ☐ NO ☐ YES: _____

Understand simple commands? ("Shut the door," "Get the ball") ☐ YES ☐ NO: _____

Retrieve/point to object after hearing its name? ☐ YES ☐ NO: _____

Answer yes/no questions related to wants? ("Do you want more?") ☐ YES ☐ NO: _____

Answer simple yes/no questions? ("Is that a dog?") ☐ YES ☐ NO: _____

Respond to who/what/where/when/why questions? ☐ YES ☐ NO: _____

Other Therapies

Physical therapy? ☐ NEVER ☐ IN THE PAST ☐ CURRENTLY

Occupational therapy? ☐ NEVER ☐ IN THE PAST ☐ CURRENTLY

Counseling? ☐ NEVER ☐ IN THE PAST ☐ CURRENTLY

Swallowing

Does your child: ☐ CHOKE DURING MEALS ☐ PUT TOYS/OBJECTS IN MOUTH ☐ BRUSH TEETH (or allow brushing)

Is your child a "picky eater"? ☐ NO ☐ YES, foods eaten include: _____

Behaviors

☐ Cooperative ☐ Attentive ☐ Willing to try new activities ☐ Plays alone for a reasonable length of time

☐ Withdrawn (prefers isolation) ☐ Poor eye contact ☐ Poor social skills ☐ Inappropriate behavior

☐ Restless ☐ Impulsive ☐ Easily distracted ☐ Daydreamer ☐ Separation difficulty

☐ Stubborn ☐ Easily frustrated ☐ Aggressive with others ☐ Destructive ☐ Self-abusive

Any additional comments?

_____

_____

_____

_____

_____

_____

_____ _____ _____

SIGNATURE RELATIONSHIP DATE

Please return by email to info@kissimmeespeech.com, or fax to (321) 333-5682

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