Speech Therapy Services
New Client Intake Form

Client Name:_____ D.O.B._____ Date:_____

Address:_____ Phone: _____

School:_____ Grade:_____ Age: _____

Information given by: _____ Relationship to child: _____

Developmental History
At what age did the child do the following?
Crawl:_____ Walk: _____
Babble:_____ First word: _____ Combine words:_____

Family History
List names and ages of siblings:_____
What languages are spoken in the home?_____
What is the child's primary language?_____

Medical History
Has the child had any severe injuries or illnesses? (indicate type and dates)
_____
_____
Medications the child has taken or been exposed to in past/present and reason:
_____

Has the child had any of the following? (indicate dates)
Head injury_____Ear infections_____
Fainting/seizures_____ Frequent colds_____
High fevers _____ Chronic congestion _____
Sleep disturbances_____
Allergies_____
Vision problems_____ Tonsil/adenoid problems_____
Hearing problems_____ Asthma_____
Other, explain_____
_____
Has the child had a hearing testing/screening?_____ Date: _____
Outcome of hearing
testing/screening:_____

Has the child ever received speech/language services? What treatment approaches were used? (PROMPT, etc.)

_____
_____

Primary Communication Concern:

_____
_____

What are the child's interests?

_____
_____

What are the child's strengths?

_____
_____

What are the child's challenges?

_____
_____

Please reach out if you have any questions!