LOS ANGELES SPEECH AND LANGUAGE THERAPY CENTER, INC.
5761 Buckingham Parkway
Culver City, CA 90230
(310) 649-6199
FAX: (310) 649-5597

SPEECH AND LANGUAGE INTAKE FORM

Today's Date: _____

1._____
Client's Name Date of Birth Telephone

2._____
Address City Zip Code

3._____
Parents or Guardian

4._____
Name of person filling out questionnaire

5._____
Child's Pediatrician Address Phone Number

6._____
If Regional Center client, list name of Regional Center and Case Manager

7. Other children in the family:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

8. Language(s) spoken in the home_____

9. What does your child call you? (Mommy, grandma, first name)_____

History of Pregnancy and Birth

1. Length of pregnancy_____

2. Were there any unusual conditions prior to, during, or immediately after birth? (i.e. High fever, exposure to drugs and/or alcohol, measles, use of oxygen, placed on a respirator, etc.)

_____

_____

_____

_____

3. Baby's condition at birth:

Birth weight: _____lbs. _____oz.
Irregular heart rate: _____yes _____no
Trouble breathing: _____yes _____no

Other:

_____

_____

4. Did the child come home from the hospital with the mother? _____yes _____no

5. Did your child have: Feeding problems_____
Seizures_____

6. Has your child ever been examined by a specialist other than a pediatrician or a family doctor? Yes_____ No_____ If yes, please indicate by whom and date of evaluation:

Speech-Language Pathologist: Date: _____ Psychiatrist: _____ Date: _____
Audiologist: Date: _____ Psychologist: _____ Date: _____
Neurologist: Date: _____ Feeding Specialist: _____ Date:_____

Other_____

_____

Development

1. When did he/she sit alone? _____Crawl alone? _____

2. When did he/she first walk unaided? _____

3. Does he/she fall or lose his/her balance easily?_____

4. Does he/she have difficulty chewing or swallowing? _____

5. At what age did your child say his/her first words?_____
   At what age did your child put 2-3 words together in a phrase?_____

6. Did he/she continue to develop speech in what you consider a "normal progression?" If not, explain: _____

   _____

7. Did speech learning ever seem to stop for a period?_____

8. Has he/she ever talked better than he/she does now?_____

9. How much of the child's speech can the care provider understand?

_____about half _____more than half _____less than half

10. Is your child's voice any of the following?

    Very soft_____ very loud_____ hoarse_____ nasal_____ other_____

11. Does your child use gestures (e.g. pointing, etc.) and/or signs to help others understand?

_____

List the signs_____

12. Give examples of words your child uses:_____

_____

13. Please describe your child's problem or your concern about him/her:_____

_____

_____

_____

_____

14. Does he/she seem to be aware of his/her speech difference? If so, what is his/her reaction?

_____

_____

Medical, Social, Educational

1. Childhood illnesses: (indicate what age, how severe, special treatment, or medication)

Measles: Date: _____ Describe: _____

Ear Infections: Dates: _____ Describe: _____

Asthma: Date: _____ Describe: _____

Other: _____

2. Has your child ever had an accident or been hospitalized for any reason? Yes____ No____

3. Is your child in good health at this time? _____

4. Is this child harder to manage than other children?_____

_____

_____

5. At what age did your child enter school?_____
Were grades repeated? Yes_____ No_____

6. Comments by your child's teacher(s)_____

_____

7. Name of School_____

8. What are his/her usual grades? (Good, fair, average, failing)_____

9. List the types of toys your child prefers to play with._____

_____

10. List the types of toys, animals, etc. your child is not allowed to play with.

_____

_____

11. What efforts have been made to help the child's speech and language?_____

_____

_____

12. Is there any information you would like to share with us about your child?_____

_____

_____

_____

_____

Special Services Review

Intervention Services Received	Length of Time (Begin/End)		Number of hours per week	Intervention received individually or in a group	Service Delivery Setting
Early Intervention Program				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Behavior Intervention				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Occupational Therapy				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Speech-Language Therapy				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Floortime and/or Play Therapy				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Social Skills				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Other: _____				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic
Caregiver training: _____				☐ Individual ☐ Group	☐ Home ☐ School ☐ Clinic

How many hours per day does your child spend in special education?

_____

How many hours per day does your child spend in regular education?

_____

Type of program(s) in which your child currently participates (check all that apply):

- ☐ Full-time regular education classroom without aid
- ☐ Regular education full-time with one to one aide
- ☐ Regular education with pull-out for some areas
- ☐ Special education with minimal inclusion (e.g., lunch, PE, etc.)
- ☐ Full time special education without inclusion
- ☐ Special ID/DD school
- ☐ Not in school
- ☐ Home schooling
- ☐ Other: _____

Does your child have a formal diagnosis? (circle one) YES NO

If yes, by whom?

_____

When?

_____

What types of intervention services do you currently desire? List all:

_____