LOS ANGELES SPEECH AND LANGUAGE THERAPY CENTER, INC.
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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 <u>not allowed to play with</u>.

____

____

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)		Numbe r 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:

____