Bloom
Speech & Language Services

# Pediatric Intake Form

## Client Information

| | |
|---|---|
| Child's Name | Name child goes by (if different) |
| Street Address | DOB |
| City, Zip: | |

## Parent/Guardian Information

Who does the child primarily reside with (list primary contact first)?

| | |
|---|---|
| Name | Name |
| Relationship | Relationship |
| Occupation | Occupation |
| Best method of contact? | Best method of contact? |
| Phone/Text | Phone/Text |
| Email _____ | Email _____ |

Please list the names/ages of any siblings (please include "half" and "step" siblings.)

Emergency Contact Person _____
Phone _____
Relationship to child _____

## Client History

Is the child adopted? Yes No
If yes, at what age? _____
Is the child currently in foster care? Yes No
If yes, for how long has this child been with you? _____
How long has this child been in foster care? _____

Were there any complications during pregnancy? Yes No
If yes, please explain:
Was there any alcohol or drug use during pregnancy? Yes No
If yes, please explain:

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Was the child born pre-term? Yes No
If yes, what was gestational age?
Was the child hospitalized after birth? Yes No
If yes, please explain:
Was the child part of a multiple birth (twins, triplets, etc.?)? Yes No

Please describe any other complications/injuries during pregnancy or birth not listed above:

Has the child ever been hospitalized? Yes No
If so, for what reason?
_____

Is your child taking any medication? Yes No
If so, type and dose?
_____

Please circle any existing diagnoses ***given by a medical professional*** (doctor, psychiatrist, psychologist, speech-language pathologist, audiologist, occupational therapist, physical therapist, etc.)

| | | | |
|---|---|---|---|
| Autism | Emotional Disorder | Recurrent Ear Infections | Seizures |
| ADHD or ADD | Genetic Syndrome | Recurrent Fevers | Cleft Lip |
| Allergies | Hearing Impairment | Vision Problems | Cleft Palate |
| Dyslexia | Cognitive Impairment | Learning Disability | Other: |

Additional Information about any of the above diagnoses:

Has your child had a hearing screening or evaluation? Yes No
Was it normal? Yes No
If not, please explain _____
Does your child currently have or has he/she had PE tubes? Yes No
Does your child have a history of chronic/recurrent ear infections? Yes No
If so, please give the approximate date of the last ear infection _____

Where does the child primarily spend his/her day? (Circle one)

| | | |
|---|---|---|
| School/Daycare (include name): | | Babysitter/Nanny |
| With a relative | With one parent | With both parents |

Other _____

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Are there other languages spoken at home or in primary care environment? Yes No

If so, which language(s)?

If so, in which language does the child prefer to communicate?

Does your child currently receive any type of special education? Yes No

If so, please explain:

Does your child currently receive any private services, either at home, in a clinic, or in the outpatient setting? Yes No

If so, please explain:

About what age did your child (if applicable)…

Begin to make sounds _____ Begin to copy sounds _____
Say his/her first word _____ Begin putting 2 words together _____
Begin crawling _____ Begin walking _____
Begin eating solid foods _____ Begin using whole sentences _____
Begin reading _____

Please briefly explain why you are seeking a speech/language evaluation?

Please briefly explain your chief communication or behavioral concerns in the home environment.

Please briefly explain your chief communication or behavioral concerns in the school environment (if applicable.)

What are your child's strengths?

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What are your child's favorite activities?

What is one goal you'd like to see your child accomplish in the next 6 months?

What about the next 5 years?

Annie Nichols, MA, CCC-SLP