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:

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:

Milestones/Developmental Questionnaire:

SPEECH AND LANGUAGE

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 _____

Did your child babble or make play noises during infancy? Y / N

Does your child make their needs and wants known? Y / N If yes, please describe how:

_____

Does your child have swallowing or feeding difficulties? Y / N If yes, please describe:

_____

Does your child name people and objects in their everyday environment? Y / N

Does your child attempt to imitate your speech? Y / N

How much of what your child says do unfamiliar people understand? ☐ All ☐ Some ☐ None

Does your child get frustrated when trying to communicate? Y / N

Can your child follow simple (one-step) directions? Y / N

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Estimate of Spoken Vocabulary: ☐25 words or less ☐25-50 words ☐50-100 words ☐More than 100 words

Does your child have difficulty producing specific sounds? Y/N Which sounds? _____

FINE MOTOR

Does your child stack blocks? Y / N If yes, how many?_____

Does your child scribble on paper? Y / N

Does your child copy vertical or horizontal lines? Y / N

Does your child snip paper with scissors? Y / N

Can your child turn a doorknob? Y / N

Can your child work a shape sorter? Y / N

Can your child turn book pages one at a time? Y / N

Does your child use primarily one hand when eating, coloring, and throwing, or do they switch hands frequently? Right / Left / Switch

SENSORY

Is your child bothered by getting messy? Y / N

Is your child bothered by clothing textures or clothing tags? Y / N

Is your child bothered by loud or unexpected sounds? Y / N

Does your child eat a wide variety of foods? Y / N

Does your child have difficulty transitioning or calming down independently? Y / N

SELF HELP

Is your child toilet trained? Y / N

Does your child drink from an open cup? Y / N

Does your child use a spoon at meals? Y / N

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Can your child undress themself (loose clothing)? Y / N

Can your child pull pants up/down for toileting? Y / N

Can your child dress themself? Y / N

Can your child put on shoes? Y / N

Can your child zip/unzip? Y / N

GROSS MOTOR

Check all that apply: Does your child… ☐Sit independently ☐Crawl ☐Stand independently ☐Walk independently

Can your child run and avoid obstacles in their path? Y / N

Can your child walk up and down 4 steps using a wall or rail only, not a person? Y / N

Can your child kick a ball forward? Y / N

Can your child throw a small ball forward within arm's reach of catcher? Y / N

Can your child jump up with both feet? Y / N

Can your child safely access age appropriate playground equipment? Y / N

Can your child pedal a tricycle? Y / N

OBSERVATIONS AT PLAY

How long does your child sit and play? _____

What toys does your child like to play with?

_____

What are some of your child's favorite activities?

_____

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ADDITIONAL COMMENTS

Below please write any additional comments you feel would help us get to know your child (strengths, behaviors, interests, dislikes, etc.):

Please briefly explain why you are seeking an evaluation and your chief concerns in the **home** environment:

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

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

What about the next 5 years?