SMART TALK SPEECH THERAPY

www.smarttalkspeech.com
tashac.slp@gmail.com • 702-339-5475

PATIENT INTAKE FORM

Patient Name: _____ DOB (MM/DD/YY): _____

Parent Name(s): _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Number: _____ Cell Number: _____

Email Address: _____

Child's Primary Language _____ Other Languages: _____

Insurance Carrier: _____ Policy Number: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Group Number: _____

Siblings and Other People Living in Home:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pediatrician Name: _____

Pediatrics Practice Name: _____

Pediatrician Phone Number: _____

Briefly describe your concerns about your child's speech, language, and/or learning:

_____

_____

_____

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DEVELOPMENTAL HISTORY

Pregnancy:

Length of pregnancy: _____ Health of Mother during pregnancy: _____

Any difficulties during pregnancy? ☐ Yes ☐ No

Check if any of the following apply:

☐ Injuries or disease of mother during pregnancy ☐ Toxemia

☐ Bleeding ☐ Maternal seizure disorder

☐ Mother needed medication ☐ Maternal alcohol and/or drug abuse

☐ Previous miscarriages ☐ Other: _____

Please further explain any complications during pregnancy: _____

_____

Delivery:

Type of delivery: ☐ Vaginal ☐ Caesarean Baby's birth weight: _____

Any difficulties during delivery? ☐ Yes ☐ No

Check if any of the following apply:

☐ Precipitous birth (labor less than 2 hours) ☐ Baby needed oxygen

☐ Prolonged labor (labor longer than 12 hours) ☐ Baby had respiratory distree

☐ Breech birth ☐ Jaundice

☐ Baby had cord around neck ☐ Rh incompatibility

☐ Prematurity ☐ Other: _____

Please further explain any complications during delivery: _____

_____

Adoption Information (complete only if appropriate):

Child's age when adopted: _____ Is child aware of adoption? ☐ Yes ☐ No

Other relevant information: _____

_____

Developmental Milestones:

At which age did your child:

Roll over? _____ Sit? _____ Crawl? _____ Walk? _____ Talk? _____

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MEDICAL HISTORY

Check and explain is any of the following apply:

- ☐ Allergies: _____
- ☐ Cerebral Palsy
- ☐ Cleft Lip Palate (please specify) _____
- ☐ Ear infections: Frequency _____
- ☐ P.E. tubes (which ear?) _____
- ☐ Encephalitis
- ☐ Failure to thrive
- ☐ Meningitis
- ☐ Eye disorder (specify) _____
- ☐ Wears glasses
- ☐ Seizure disorder
- ☐ Head injury
- ☐ Special diet
- ☐ Autism Spectrum Disorder
- ☐ Down Syndrome
- ☐ Other: _____

Has your child had surgery or been hospitalized?

Date:	Age:	Procedure:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your child presently taking any medication? Please specify medicines and conditions:

_____

_____

Hearing Status:

Have you ever questioned your child's hearing? ☐ Yes ☐ No

If yes, please explain: _____

Has your child had a formal hearing test? ☐ Yes ☐ No

If yes, when and what were the results? _____

Feeding:

Did your child have difficulty chewing, swallowing, or drinking? ☐ Yes ☐ No

If yes, please explain: _____

Does your child currently have difficulty eating? ☐ Yes ☐ No

If yes, please explain: _____

Play Skills:

Does your child prefer to play alone or with others? _____

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What types of toys does your child play with? _____

Family History:

Is there a family history of speech and/or language problems? ☐ Yes ☐ No

If yes, please explain: _____

Behavior Information:

Please check if your child has problems with any of the following:

☐ Attention	☐ Immaturity	☐ Poor motivation/apathy
☐ Aggression	☐ Impulsivity	☐ Shyness
☐ Anxiety	☐ Low self-esteem	☐ Short attention span
☐ Bedwetting/toileting	☐ Manipulative	☐ Sleep problems
☐ Depression	☐ Moodiness	☐ Substance abuse
☐ Disruptive behavior	☐ Nail biting	☐ Temper tantrums
☐ Difficult to manage	☐ Nightmares	☐ Tics/nervous gestures
☐ Frequent crying	☐ Noncompliance	☐ Truancy
☐ Hyperactivity	☐ Not interested in peers	☐ Other: _____
☐ Getting along with peers	☐ Perfectionism	_____

Please list any other professionals your child has seen for speech, language, and/or developmental concerns: _____

EDUCATIONAL HISTORY

Did/does your child attend school? ☐ Yes ☐ No

If yes, where? _____

Is this a private or public school? ☐ Private ☐ Public

What grade is your child in? _____

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have an Individualized Education Program (IEP)? ☐ Yes ☐ No

Does your child: ☐ Label letters ☐ Read ☐ Write

Does your child enjoy reading/having books read to him/her? ☐ Yes ☐ No

Does your child enjoy school? ☐ Yes ☐ No

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Has or is your child receiving:

	Current	Past	Age/Grade	Frequency	Location
Special Education Classes					
Remedial Classes					
Tutoring					
Speech/Language Therapy					
Physical/Occupational Therapy					
Counseling/Therapy					

Please provide any relevant details for above checked boxes: _____

_____

_____

How is your child currently doing in school? _____

_____

_____