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Child Pre-Intake History Form
Speech-Language Evaluation

Please fill out the form below as best as you can and retain a copy for your own records.
Please return completed form to above address.

General Information:

Child's name: _____ Date of Birth/Age: _____

Address: _____

Does the child live with both parents? Yes _____ No _____

Mother's name: _____

Mother's occupation: _____ phone work: _____ cell: _____

Father's name: _____

Father's Occupation: _____ phone work: _____ cell: _____

Siblings (include name and ages):

Other persons living in the home (relationship to child):

Emergency Contact:

Name: _____ phone: _____ relationship to child: _____

Language (s) spoken in the home: _____

Referral Information:

Referred by (pediatrician, teacher, self): _____

Address: _____ phone: _____

Reason for referral (specify): _____

Present Communication Status:

Describe your child's speech-language problem (In your own words):

How does your child usually communicate (gestures, single words, phrases)?

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed (describe)?

Are there any speech, language or hearing problems in your family? Please describe.

What questions do you want to have answered by this evaluation?

Educational History:

Name of school: _____ Current Grade: _____

Teacher's name: _____

Does your child have difficulty at school? If so, please describe: _____

Mandated Special Education Services:

IEP Yes _____ No _____

504 Yes _____ No _____

Type of Service:

Specialist:

Dates:

Accommodations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Non-Mandated Special Education Services:

Type of Service:

Specialist:

Dates:

Accommodations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Outpatient Treatment Providers (Occupational Therapy, Physical Therapy Speech Therapy, Psychiatry, Psychotherapy):

Type of Service

Specialist:

Dates:

Previous Clinical Evaluations (i.e. Neuropsychological Testing, Psychological Testing, etc.)

Type of testing: _____ provider _____
dates: _____ pertinent results: _____

Type of testing: _____ provider: _____
dates: _____ pertinent results: _____

Type of testing: _____ provider: _____
dates: _____ pertinent results: _____

Current Diagnosis (i.e. Autism Spectrum, ADHD, Anxiety, Language/Learning Difficulties, etc.): _____

Pregnancy and Birth History:

Length of pregnancy: _____ Type of delivery: _____

General condition: _____ Birth weight: _____

Were there any conditions that may have affected the pregnancy or birth (illnesses, accidents, medications, etc.)? _____

Developmental History:

Provide the approximate age at which the child began to do the following activities:

Crawl	Sit alone	Stand
Walk	Feed self	Dress self
Toilet trained	First words	First phrases/sentences

Does your child have any difficulty participating in activities that require small and large muscle coordination (i.e. walking, running, jumping, etc)? _____

Feeding problems (i.e. sucking, swallowing, drooling, chewing, etc):

Food/texture preferences (i.e. yogurt, crackers, peanut butter etc.): _____

Hearing difficulties: _____

Medical History:

Please indicate the age at which your child has had any of the following:

allergies	asthma	chicken pox
Colds	convulsions	Croup
dizziness	ear infections	draining ear
encephalitis	German measles	Headaches
High fever	influenza	Sinusitis
Measles	mumps	Meningitis
pneumonia	seizures	Epilepsy
Tinnitus	tonsillitis	Other

Has the child had any surgeries? If yes, what type and when (tube placement, tonsillectomy):

Major accidents or hospitalizations: (please explain) _____

Current Medications: (Please specify) _____

Side effects: _____

Provide any other information that may be helpful for the evaluation and remediation of your child's difficulties: _____

By signing this form, I am stating that all information is accurate regarding my child's treatment history and needs. I understand that any changes in my child's care must be provided in writing to the attention of Lisa Langweil, M.S., CCC-SLP.

Parent/Guardian (print name): _____

Signature of Parent/Guardian: _____ Date: _____

Received by: _____ Date: _____