



## Client Intake Form 2022

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Grade: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Child Enjoys: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Profession: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Hours per Week: \_\_\_\_\_

Favorite Activity with Child: \_\_\_\_\_

\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced

Father/Guardian: \_\_\_\_\_ Profession: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Hours per Week: \_\_\_\_\_

Favorite Activity with Child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Have you had Occupational / Speech Therapy before? \_\_\_\_ Yes \_\_\_\_ No

When: \_\_\_\_\_

Who may we thank for referring you to our office?: \_\_\_\_\_

Physician/Pediatrician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Pediatric Health History/Development

1. Please describe any significant illnesses/difficulties/traumas during the pregnancy with this child:

\_\_\_\_\_  
\_\_\_\_\_

2. Please check off all that apply to the birth of this child: Home birth \_\_\_\_\_ Hospital \_\_\_\_\_  
Epidural \_\_\_\_\_ Episiotomy \_\_\_\_\_ Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ C-section \_\_\_\_\_  
Vacuum \_\_\_\_\_ Manual Assistance \_\_\_\_\_ Medications \_\_\_\_\_

3. Length of Labor: \_\_\_\_\_

4. Was the baby breastfed? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

5. Has your child received vaccinations YES or NO Complete for their age: \_\_\_\_\_ Partial: \_\_\_\_\_  
No vaccinations: \_\_\_\_\_

6. Age child rolled: \_\_\_\_\_ Age child talked: \_\_\_\_\_ Age child crawled: \_\_\_\_\_  
Age child walked: \_\_\_\_\_
7. What time does the child go to bed?: \_\_\_\_\_ How long to they sleep?: \_\_\_\_\_  
Any concerns with sleeping and the bedtime routine:  
\_\_\_\_\_
8. What does the child eat?: \_\_\_\_\_  
Any eating concerns: \_\_\_\_\_
9. Child's Activity/exercise level: \_\_\_\_\_ Hrs per week: \_\_\_\_\_  
Do they play any sports?: \_\_\_\_\_  
Any concerns with movement/activity level?: \_\_\_\_\_
10. Mental Health concerns?: \_\_\_\_\_
11. Please describe any falls, stitches, fractures, car accidents, sports injuries or other traumas that your child experienced since birth (include ages and dates):  
\_\_\_\_\_  
\_\_\_\_\_
12. Please tell us about any health issues/chronic illnesses that the child has had since birth (include ages/dates): \_\_\_\_\_
13. Any known food allergies: \_\_\_\_\_ Special Diet?: \_\_\_\_\_
14. Please list any medications the child is taking: \_\_\_\_\_
15. Any supplements?: \_\_\_\_\_
16. Please list any emotional/social/academic stressors in the child's life.  
\_\_\_\_\_  
\_\_\_\_\_
17. Main Concern(s) for Child:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. Family History/What Runs in the Family?:  
\_\_\_\_\_  
\_\_\_\_\_
19. Lives with? (siblings?): \_\_\_\_\_

**SPEECH ONLY SECTION:**

1. Does your child have difficulty understand things you say to them? (receptive communication) \_\_\_\_\_
2. Does your child have difficulty using language to communicate to you? (Expressive) \_\_\_\_\_
3. Does your child have difficulty with certain sounds when speaking? (Articulation) \_\_\_\_\_
4. Does your child have difficulty using language in social settings? (Pragmatics) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_