mansfield pediatric therapy

Speech-Language Pathology Case History Intake Form

Demographics		
Name:		Date of Birth:
Preferred Name:		
Ethnicity/Race:	Age:	Gender:
Primary language:		Second language(s):
Parent/Guardian name(s):		
Preferred phone number: ( ) -		Other phone number: ( ) -
Address:		
Preferred email:		
Preferred method of correspondence: ☐ phone call ☐ email ☐ text ☐ other:		
Parent(s) occupation(s):		
Referred by:		
Doctor:	Phone Number: ( ) -	Fax Number: ( ) -
Office/clinic name:		
Address:		

Insurance	
Insurance company/plan:	Phone number:
Fax number:	Policy holder:
Policy holder DOB:	Policy number:
Does your insurance plan cover speech/language therapy?	

Social History
Child lives with (check all that apply): ☐ birth parents ☐ adoptive parents ☐ single parent
☐ parent & step-parent ☐ foster parent(s) ☐ other:
Parents are (select): ☐ married ☐ separated ☐ divorced ☐ other:
Siblings (names & ages):
Additional people living in the home:
Hobbies/interests/likes:
Dislikes:
Strengths:

Family History	
Please select all that apply:	
☐ Speech/Language Difficulties	Relationship to child:
☐ Autism	Relationship to child:
☐ Childhood Hearing Loss	Relationship to child:
☐ Learning Disabilities	Relationship to child:
☐ Dyslexia	Relationship to child:
☐ ADHD/ADD	Relationship to child:
☐ Fluency/Stuttering	Relationship to child:
☐ Genetic diagnosis	Relationship to child:
☐ Craniofacial/cleft lip or palate	Relationship to child:
☐ Other Hearing Impairment/Deafness	Relationship to child:

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Speech/Language Therapy Referral Questions
Why is this speech/language evaluation being requested?
Please describe your concerns for your child's speech/language (if different from above question) and how long you have been concerned with your child's speech/language skills:
What is your goal for speech/language therapy?

Medical History		
Birth: ☐ full-term ☐ premature: _____ weeks		
Brith complications (if any):		
Pregnancy compications (if any):		
NICU or Special Care Nursery Stay: ☐ yes _____ (length of stay) ☐ no		
Date of last well-visit:		
Please select all that apply:		
☐ Tonsilectomy	☐ Adenoidectomy	☐ Ear infections
☐ Ear (PE) Tubes	☐ Nasal Congestion	☐ Frequent illness
☐ Seasonal Allergies	☐ Allergies	☐ Difficulty sleeping
☐ Snoring	☐ Sinus issues	☐ ADHD/ADD
☐ Vision Difficulties	☐ Glasses	☐ Autism
☐ Hearing Difficulies	☐ Frequent tonsillitis	☐ Anxiety
☐ Failure to Thrive	☐ GERD	☐ Diabetes
☐ Encephalitis	☐ Torticollis	☐ Seizures
☐ Hydrocephaly	☐ CMV	☐ Meningitis
☐ Dizziness	☐ Pneumonia	☐ Tinnitus
☐ Respiratory issues	☐ Cardiac issues	☐ Paralysis
☐ Stroke/CVA	☐ Cerebral Palsy	☐ ODD
☐ Mood disorder(s)	☐ Depression	☐ OCD
☐ Cleft lip or palate	☐ High fevers	☐ Headaches
☐ Concussion/Head Injury	☐ Cancer	☐ Genetic
☐ Other:		
Hospitalizations/surgeries & dates:		
Is your child under the care of any other medical specalists? If so, please list the specality and provider name:		

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Medications:		
Screening History		
Date of last hearing screening:	☐ pass ☐ fail ☐ unsure ☐ N/A	
Date of last vision screening:	☐ pass ☐ fail ☐ unsure ☐ N/A	
Did your child pass his/her newborn hearing screening?	☐ pass ☐ fail ☐ unsure	
Did your child pass any dyslexia screenings through school?	☐ pass ☐ fail ☐ unsure ☐ N/A	
Other vision or hearing evaluations & results:		
Feeding & Eating History		
Please select all that apply:		
☐ Thumb/finger sucking	☐ Prolonged bottle use	☐ Tube feeding
☐ Messy eater	☐ Limited diet	☐ Food allergies
☐ Weight issues	☐ Dehydration	☐ Consitpation or diarrhea
☐ Other GI issues	☐ Picky eater	☐ Texture avoidances
☐ Other avoidances	☐ Cup/bottle preference	☐ Reflux/GERD
☐ Grazing	☐ Drooling	☐ Mouth breathing
☐ Open mouth at rest	☐ Tongue thrust	☐ Tongue/lip tie
☐ Difficulty transitioning to solids	☐ Diffiulty using utensils	☐ Difficulty with an open cup
☐ Sensitive gag reflex	☐ Choking or coughing	☐ Difficulty nursing/bottle feeding
Other feeding issues/concerns (if any):		
Does your child breathe through their: ☐ mouth ☐ nose ☐ unsure		
Any oral structure issues:		
Has your child been to the dentist (if so, provide name): ☐ yes, _____ ☐ no		
Any dental issues reported:		
Educational, Academic, Therapuetic History		
**if your child is not yet preschool aged, please proceed to Speech Language & Development History*		
Grade:	School:	
School district of residence (if different)	Academic performance:	
Other districts attended & grade levels:		
What grade level was your child impacted by COVID-19?		
Did your child participate in Early Intervention and/or Help Me Grow? ☐ yes ☐ no		
Did your child attend preschool? ☐ yes, _____ years ☐ no		
Does your child have an IEP? ☐ yes ☐ no		
If yes, what service(s) and/or accomodations:		
Does your child have a 504 Plan? ☐ yes ☐ no		
If yes, under what eligibility/diagnosis:		
Is your child receiving Tier I, Tier II, or Tier III instruction? ☐ Tier I ☐ Tier II ☐ Tier III ☐ unsure		
Does your child participate in private tutoring? ☐ yes, _____ months/years/times each week ☐ no		
Does your child receive any other help at school and/or Title I Reading Remediation? ☐ yes ☐ no		

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Has your child ever repeated a grade? ☐ yes, _____ grade ☐ no		
Is your child reading? ☐ yes ☐ no		
Does your child understand what he/she reads? ☐ yes ☐ no		
Does your child undersand better when text is read to him/her? ☐ yes ☐ no		
Is your child able to get his/her thoughts on paper? ☐ yes ☐ no		
Does your child write legilbly? ☐ yes ☐ no		
Do you have concerns with your child's reading or writing skills? ☐ yes. ☐ no		
Did your child have a difficult time learing to read? ☐ yes ☐ no		
Did your child have difficulty learning letters, the alphabet, rhyming, letter sounds, etc.? ☐ yes. ☐ no		
Subject areas of strength:		
Subject areas of difficulty:		
Does your child receive therapy at school and if so, which therapies? ☐ yes (circle): Speech | OT | PT ☐ no		
Has your child ever received a speech/language evaluation (school or otherwise)? ☐ yes ☐ no		
If so, was it through school, oupatient clinic, private clinic?		
If so, what was the date of the most recent speech/language evaluation?		
Speech Language & Developmental History		
Please indicate approximate age at which your child reached the following milestones:		
☐ Babbling:	☐ First word:	☐ 2-words together:
☐ Siting independently:	☐ Crawling:	☐ Walking:
Do you have any sensory processing, fine motor, handwriting, or gross motor concerns for your child? ☐ yes ☐ no		
Was your child a quiet baby (limited vocalizations, babbling)? ☐ yes ☐ no		
Are there any sounds that your child has difficulty producing? ☐ yes ☐ no ☐ sounds:		
Is your child aware of or frustrated by any speech difficulties? ☐ yes ☐ no		
Does your child seem to have difficulty finding the right word to say? ☐ yes ☐ no		
Does your child require repetitions to complete tasks? ☐ yes ☐ no		
What are your concerns (if any) in regards to your child's speech production/articulation?		
What are your concerns (if any) in regards to your child's ability to understand and express language?		
Please provide an example of a typical speech production error (if any) produced by your child:		
Estimated percent of the time that you understand your child:		
Estimated percent of the time that someone else would understand your child:		
Primary communication methods (select all that apply):		
**if your child is over the age of 5, please skip to the last question/statement*		
☐ Crying/whining/screaming	☐ Eye gaze	☐ Sign language
☐ Pointing	☐ Leading	☐ Bringing items to adult
☐ Gestures	☐ Words more than gestures	☐ Phrases
Does your child seem to understand more than he/she is able to understand? ☐ yes ☐ no		
Does your child seem to have equal difficulty in understanding and speaking language? ☐ yes ☐ no		
My child uses approximately how many words (only estimate if child is using less than 250 words):		

Does your child (select all that apply):		
☐ Follow simple directions	☐ Play with others	☐ Point to pictures
☐ Respond to yes/no questions	☐ Imitate	☐ Learn new words frequently
☐ Answer questions	☐ Understand what you are saying	☐ Imitate
☐ Respond to "no"	☐ Respond to their name	☐ Enjoy books
If you answered "no" to any of these please explain:		
Please attach any other specialist reports, reports of diagnoses, significant medical history reports, other speech/language evaluations, therapy (physical/occupational) evaluations, vision or hearing testing, IEP/504 Plan/ETR, and/or other school evaluations.		