Beckman and Associates
Speech Therapy Intake Sheet Form

Name: ________________________________ Date of Birth: ___________________

Address: ____

E-Mail: ____

Phone: _________________ Best # to reach you on appt. date: _______________________

Parent / Legal Guardian Names: ____

Child lives with both parents? ☐ YES ☐ NO If no, with whom? _________________________

STATEMENT OF PROBLEM

Please state in your own words what do you think the child's problem is, and what you think might have caused it.

____

____

____

When did you first notice the problem?

____

Pediatrician: ____________________________ Phone: _________________________

Current Medications: ____

Other doctors (dentists/orthodontists/psychologists) that provide care to this child:

Name	Specialty	City
______________________	___________________	_________________
______________________	___________________	_________________

Previous evaluations (list):____

Diagnosis: ______________________ Made by: ________________ When:___________

Has your child received any therapy to date (list): How long? By whom?

____

____

Describe present problem: ____

____

Who noted present problem? _______________ When? ____________________________

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PRENATAL/BIRTH HISTORY

Full Term: ☐ YES ☐ NO If no, how many weeks?______________________________

Birth Weight: __________________ Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech ☐ Feet First

Illnesses or accidents during pregnancy: ______________________________________

Medications used during pregnancy:____

What was the length of the labor?___________ Mothers health during pregnancy?________________

Was labor induced or spontaneous?____

If induced, length of time on Pitocin?_______________________________________

Was fetal distress noted? ____________________Was oxygen required?_____________________

Did the child have problems breathing at birth? __________________Sucking? _________________

Fed via breast, bottle or Non-Oral? ____

Any concerns that may have affected gestation /birth? (Respiratory, circulatory, gastrointestinal)

____

____

MEDICAL HISTORY

Please check if your child had had any of the following (and if so, at what age):

☐ Seizures	☐ High fevers	☐ Measles	☐ Mumps	☐ Chicken Pox	☐ Whooping cough
☐ Diphtheria	☐ Croup	☐ Pneumonia	☐ Tonsillitis	☐ Meningitis	☐ Encephalitis
☐ Rheumatic fever	☐ Tuberculosis	☐ Sinusitis	☐ HIV	☐ Enlarged glands	
☐ Thyroid	☐ Asthma	☐ Heart trouble		☐ Chronic colds	

Please explain any checked items here: _______________________________________

____

Are immunizations current: __________________

Has your child had any earaches/ear infections? ☐ YES ☐ NO Please explain below:

____

____

Allergies? (Describe)____

Any constipation? _________________________ Is bowel flow/BM daily? ☐ YES ☐ NO

Any reflux/vomiting? ____

Any other serious or recurrent illnesses?_______________________________________

Any operations?____

Any accidents?____

Any medications? (Past) ________________________ (Present) ________________________

Vision Problems?____

Hearing difficulties?:____

Has your child had a hearing test? ________ When? ______________ By whom?______________

Other Medical History?

____

____

DEVELOPMENTAL HISTORY

Has your child had any feeding difficulties? Check each item that applies.

☐ Sucking or nursing
☐ Regurgitation of liquids or solids through the nose
☐ Excessive length of time to drink bottle
☐ Difficulty chewing or swallowing meats

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

_______ Sat up alone _______Crawled _______ Walked _______ Make wants known

_______ Eat pureed fruits/veggies _______ Eat pureed meats _______ Eat raw fruits/vegetables

_______ Used a straw _______ Used cup without lid _______ Attention span for self directed activities

Does your child choke while eating? ☐ YES ☐ NO

If "yes", on what foods? ____

Is your child a picky eater? ☐ YES ☐ NO

If "yes", what foods does s/he prefer? ____

Does your child drool more than other children his/her age? ☐ YES ☐ NO

Does your child have difficulty gaining weight as an infant? ☐ YES ☐ NO

Did or does your child suck their thumb? _______________________________________

Does your child use a pacifier? ________________________ What type?______________________

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LANGUAGE DEVELOPMENT

How well is your child understood by: (i.e., what percentage of the time?)

Mom: _________________ Dad: ________________ Unfamiliar Adults: ___________________________

Has your child received speech treatment? ________ How long? _______ By whom? __________________

Describe what is like to have a conversation with your child:

____

____

Language(s) spoken in home: ____

Which are spoken by the child?____

Which are understood by the child?____

How many words can your child say? (List if fewer than fifteen)

____

____

Does your child have difficulty following directions? (Describe)

____

Any speech or hearing problems in the immediate or extended family (explain)?

____

Age	Behavior	Age	Behavior
_______	cooing, pleasure sounds	_______	Single words
_______	babbling (ba-ba,da-da)	_______	phrases (go bye-bye)
_______	Jargon (talking own special language)	_______	short sentences

What is the primary method(s) your child uses for letting you know what she/he wants?

- ☐ Looking at objects
- ☐ Crying
- ☐ Single words
- ☐ pointing at objects
- ☐ vocalizing/ grunting
- ☐ 2-3 word combinations
- ☐ gestures
- ☐ physical manipulation
- ☐ sentences

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Which of the following best describes your child's speech?

- ☐ Easy to understand
- ☐ Difficult for parents to understand
- ☐ Difficult for others to understand
- ☐ Almost never understood by others
- ☐ Different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

- ☐ Is easily frustrated when not understood
- ☐ Has been teased about their speech
- ☐ Does not seem aware of speech/communication problem
- ☐ Tries to say sounds or words more clearly when asked
- ☐ Is successful in saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds ☐ YES ☐ NO

If "yes", which ones? ____

PLAY BEHAVIORS

Which of the following describes the type of play your child likes to engage in the most often?

- ☐ Putting toys in mouth
- ☐ Banging toys together
- ☐ Throwing toys
- ☐ Shaking toys
- ☐ Pushing/pulling toys
- ☐ Role-playing
- ☐ Acting out familiar routines
- ☐ Games with rules
- ☐ Rough and tumble play
- ☐ Looking at books

What is the length of time your child can stay playing at one activity?

____

What activity seems to hold your child's attention for the longest period of time?

____

Which activities seem to hold your child's attention for the shortest period of time?

____

SCHOOL HISTORY

Educational Setting	Location/School	Teacher(s)	Special Services?
Child Care Facility			
Early Childhood Classes			
Pre-School			
K-5			
Middle School (6 to 9)			

Current School and Grade:____

Completed by: ____________________________(Sign your name) Date:__________________