

Speech & Language Consultants, LLC
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Trumbull, CT 06611
Phone (203) 374-3100
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Client Intake Form

Name: _____ Age: _____ DOB: _____

Address: _____
Street City/Town State zip code

Gender: Male Female

Parent/Guardian: _____

Daytime Phone: _____

Mobile Phone: _____

E-mail: _____

Does the child have siblings?

Name	Age	Gender	Grade
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Name	Age	Gender	Grade
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Primary Physician: _____

Does your child have any allergies? : _____

If so, please specify:

Please list any medications your child takes regularly: _____

Current DX: _____

School: _____

Is your child receiving services at school? _____

If so, please describe type and frequency of service _____

Is there a second language spoken at home? : _____

If so, please specify: _____

Does the child speak the language? : _____

Does the child understand the language? : _____

Current Levels/Concerns

Reading: _____

Oral Language: _____

Written Language: _____

Comprehension: _____

Speech: _____

Pragmatic Language

Eye Contact: _____

Conversation Turn-Taking: _____

Joining a Group: _____

Regulation of Physical Self: _____

Engagement with Others: _____

Understanding Facial Expressions: _____

Understanding Vocal Tones/Inflections: _____

Attention: _____

Memory: _____

Coordination (fine motor): _____

Behavioral Characteristics (please circle the following)

Cooperative

Restless

Attentive

Poor eye contact

Willing to try new activities

Easily distracted/short attention

Plays alone for reasonable length of time

Destructive/aggressive

Separation difficulties

Withdrawn

Easily frustrated/impulsive

Inappropriate behavior

Stubborn

Initiating conversation

Please describe your child's sensory needs: _____

Please tell the approximate age your child achieved the following developmental milestones:

Sat alone _____

Grasped crayon/pencil _____

Babbled _____

Said first words _____

Put two word together _____

Spoken in short sentences _____

Walked _____

Toilet trained _____

Does your child ...

Choke on food or liquids? _____

Currently put toys/objects in his/her mouth? _____

Brush his/her teeth and/or allow brushing? _____

Have sensitivity to certain foods or textures? _____

Please describe any concerns with food or swallowing? _____

Please describe the services you are interested in?

Recommendations: Completed by Therapist
<input type="checkbox"/> File Review
<input type="checkbox"/> Evaluation
<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Language Therapy
<input type="checkbox"/> Reading/Writing Improvement
<input type="checkbox"/> Contact other therapists/teachers/school observation