Inspiring Talkers
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Therapy Intake Form

Today's Date:_____

General Information:

Full name of child: _____
DOB:_____ Male/Female: _____
Parents/Guardians Name #1: _____ Parents/Guardians Name #2: _____
Address:_____
City:_____ County:_____
State:_____ Zip:_____
Home Phone:_____ Cell Phone #1:_____ Cell Phone #2:_____
Email Address:_____
With whom does the child live:_____
Language(s) spoken in the home (please list):_____
Name of sibling(s) and age(s): _____

Primary Physician:_____Phone: _____
Fax:_____

What Services Are You Here For?

□ Speech Therapy □ Physical Therapy
□ Occupational Therapy □ Assistive Augmentative Communication Device
□ Other: _____

Who referred you for your evaluation(s):_____

What Are Your Primary Concerns?

□ Fine Motor (ie. Hand writing, buttoning, etc) □ Feeding
□ Self-Care □Organization/Time Management
□ Sensory Difficulties □ Behavior
□ Speech □ Gross Motor Skills/Coordination
□ Language (ie. Vocabulary, grammar, etc) □ Balance
□Social Skills □ Safety
Other: _____

Pregnancy and Birth History:

Relation to Caregiver: (circle) Biological Adopted Foster Child Other:
Was your child born full term? (circle) YES NO
Type of delivery? (circle) head first feet first caesarian
Were there any pregnancy or birth complications or prematurity? (explain)_____
_____

Medical History:

Has a professional ever given your child a specific diagnosis? (mark all that apply)

□ A.D.D./A.D.H.D.
□ Autism/PDD
□ Behavior Disorders
□ Cerebral Palsy
□ Cleft Lip/Palate
□ Cognitive Delays
□ Developmental Delay
□ Down Syndrome
□ Failure to Thrive
□ Hearing Problems
□ Seizure Disorder
□ Emotional Disorder (anxiety, depression, ODD, etc.)
□ Other _____

Seizures**:** YES NO If yes, type and frequency: _____

Has your child had any illnesses: YES NO

If yes, what diseases/illnesses or allergies ? (Check all that apply)

□ Allergies List:_____
□ Asthma
□ Frequent Ear Infections
□ Pneumonia
□ RSV
□Other:_____

Has your child had any surgeries? (e.g. Pressure equalization tubes, tonsillectomy, adenoidectomey, botox injections etc). If yes, what type and when?

_____
_____
_____

Does your child take medications for any reason? YES NO
If yes, please list the medication(s) and reason(s) for taking them._____
_____
_____

Vision:

Please indicate which category best describes the child's vision:

□ Normal
□ Visual impairment, correctable with lenses
□ Visual impairment, not correctable with lenses
□ Legally blind
□ Totally blind
□ Cortical vision impairment (CVI)

Please indicate area(s) of difficulty:

□ Seeing a standard computer screen
□ Seeing the whiteboard in a classroom
□ Seeing to read
□ Complains of eye fatigue or pain
□ Seeing the keys on a standard keyboard
□ Difficulty finding objects in busy background
□ Difficulty copying shapes
□ Other:_____

Hearing:

Please indicate which category best describes the client's hearing:

□ Normal
□ Hearing impairment, assisted by hearing aid/ implant
□ Hearing impairment, without hearing aid/implant
□Other:_____
□ Deaf
□ Central Auditory Processing Disorder (CAPD) –
Diagnosis date: _____

Related Services:

Please indicate if the client has received(start and end date) or is currently receiving the following evaluations or services. Please include copies of relevant reports.

□ IEP: _____
□ Assistive Technology: _____
□ Occupational Therapy: _____
□ Physical Therapy: _____
□ Speech Therapy: _____
□ Hearing Therapy: _____
□ Vision Therapy: _____
□ Behavioral Therapy:_____
□Mental Health Therapy:_____
□Other (Music, Massage, Chiropractor, etc.)_____

At what age did your child reach the below developmental milestones?

Crawling:_____
Sitting independently: _____
Standing independently: _____
Walking: _____

Jumping: _____
Run: _____
First Word: _____
2-3 word phrases_____
Full Sentences_____

Physical Status:

Gross Motor Status

□ walks independently, with no balance or safety concerns.
□ walks independently but need supervision for safety.
□ walks independently using assistive device (i.e. crutches, walker, cane..)
□ can walk for short distances with physical assistance of another person.
□ unable to walk.
□Seems clumsy, bumps into things
□Difficulty participating in sports or using playground equipment

Fine Motor Status

□ Has difficulty or avoids writing, drawing, coloring, or cutting (Circle all that apply)
□Has difficulty with buttons, zippers, or tying shoes (circle all that apply)
□Has difficulty using fork, spoon, or toothbrush (circle all that apply)
□Has difficulty or avoids fine motor games or activities (Legos, lacing cards, building blocks, etc.)

If applicable, please describe current equipment, tools, resources used at home or at school to support your child. (e.g. walkers, glasses, hearing aid, standers, prosthetic device, bath chair, Augmentative/Alternative communication devices, etc.)

_____
_____
_____

Sensory:

□ Overly sensitive to being touched
□ Unaware of being touched or bumped
□Excessive mouthing of objects for age (pencils, shirt, hands, etc.)
□ Avoids putting hands in messy substances (paint, glue, clay)
□Extremely picky eater
□ Overly sensitive to noises (toilet flush, bells, whispering, etc.)
□ Hesitant to climb stairs or playground equipment
□ Other _____

Self-Care: Indicate how much of activity they do independently in the space (ie. Child does 75% of dressing independently, 25% of toileting independently, etc.)

□ Putting on shirt and pants _____
□ Putting on socks and shoes _____
□ Doing buttons, zippers, snaps_____
□ Showering/bathing_____
□ Brushing Teeth_____
□ Washing Hands_____
□ Brushing Hair_____
□ Toileting _____

Communication Skills:

Receptive Language

Please describe your child's ability to understand language:_____
_____
_____

Please indicate the child's current level of understanding by checking one of the following:

□ Does not understand spoken words
□ Understands 2 & 3 part commands
□ Understands single words
□ Understands conversation
□ Understands simple sentences
□Understands opposites
□Understands basic concepts (tall, wet, broken, etc.)
□Understands time concepts (telling time, before/after, etc.)

Expressive Language

Please describe your child's ability to express information:_____
_____
_____

Who does the child attempt to communicate with?_____

Can the child be understood by unfamiliar people? YES NO

Who can understand this child's speech and how well? *Please check all that apply.*

	Always	Sometimes	Never		Always	Sometimes	Never
Strangers				Parents			
School				Siblings			
Peers/friends				Others:			

What does the child do when he/she is not understood? Please explain: (e.g., repeats same message, modifies message, stops trying to communicate, gets frustrated, cries, etc.)._____
_____

The child presently attempts to communicate using: (check all that apply)

□ pointing	□ vocalizations	□ semi-intelligible speech
□ augmentative communication	□ sign language	□ single words
□ gestures	□ writing	□ 2-word utterances
□ sign language approximations	□ reliable "yes/no" response	□ 3-word utterances

□ other _____

Augmentative Communication: □ N/A

If the child has ever been evaluated for AAC use, please indicate when and summarize recommendations._____
_____

Does the child currently use any type augmentative communication system or device? (describe)
_____
_____

How many vocabulary items are displayed on child's device? _____

What size are the pictures/symbols on child's board/device? (i.e. 1" square) _____

How does the child access the device (i.e. direct select, visual scanning, auditory scanning, etc.)?
_____

How long has the child been using the device or system described? _____

What have been the child's successes and/or difficulties using the device or system described?
_____
_____

Please list any other communication devices or systems used in the past.
_____ □ successful □ unsuccessful
_____ □ successful □ unsuccessful
_____ □ successful □ unsuccessful

Other:

What do you expect from this assessment? _____
_____
Please include any other information you feel is important. _____
_____
_____