NoVa
Northern Valley Speech Language and Learning Center

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PARENT INTAKE

Child's Name: _____

Date of Birth: _____

Mother's Name:_____ **Occupation:-**_____

Father's Name:-_____ **Occupation:**_____

Siblings: _____ **Age:**_____

_____ **Age:**_____

_____ **Age:**_____

Home Address:_____

Home Phone Number:_____ **Cell Phone:** _____

E-Mail Address: _____

Referral Source: _____

Primary Care Physician: _____

Parent's Statement of Concerns:_____

_____

_____

_____

_____

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth?_____

If yes, please describe_____

_____

Was the mother sick during pregnancy?_____

If yes, please describe_____

_____

What was the length of pregnancy: _____ Any complications upon delivery? _____

_____

What was the apgar score:_____

Did the child go home with his/her mother from the hospital? _____

If the child stayed at the hospital, please describe why and how long_____

_____

_____

MEDICAL HISTORY

Has your child had a history of allergies, frenutectomy, adenoidectomy, ear infection, ear tubes, tonsillectomy and tonsillitis? _____

_____

Has your child had any history of head injury, seizures, or serious injuries?_____

_____

Is your child currently, under a physician's care? _____

If yes, why _____

_____

Does your child take any medications regularly? _____

Does your child suck their thumb or finger? _____

FAMILY BACKGROUND

Primary Language Spoken at Home: _____

Secondary Languages:_____

Does the child speak another language: ___ **yes** ___**no**
Does the child understand another language: ___ **yes** ___**no**

Is their any familial history of speech, language or learning difficulties? _____

If yes, describe: _____

_____

Are any family members receiving speech/language therapy currently?_____

_____

_____

DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following milestones

_____**sat alone**

_____**crawled**

_____**dressed his/her self**

_____**babbled**

_____**put two words together**

_____**grasped crayon/pencil**

_____**walked**

_____**used utensils**

_____**first words**

_____**spoke in short sentences**

Does your child repeat sounds, words or phrases? _____

Is your child understood by others? _____

Does your child follow simple directions? _____

Does your child follow multiple step directions? _____

Does your child answer questions? _____

How does your child communicate? _____

_____

What does your child do when frustrated? _____

_____

Can your child attend to age appropriate activities? _____

What is your child's preferred activities? _____

_____

Does your child separate easily? _____

Does your child engage with his peers?_____

Has your child's hearing been checked? _____

Has he/she ever had a speech evaluation/ screening or speech therapy?_____

If yes, describe: _____

_____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, counseling, vision therapy, etc.):_____

If, yes describe: _____

_____

SCHOOL HISTORY

Does your child attend school? _____

If yes, what is the name of the school and the grade level? _____

_____

What is the teacher's name: _____

What are your child's best subjects:_____

_____

Is your child having difficulty with any subjects?: _____

_____

If yes, which subjects? _____

Is your child receiving any help in any subjects: _____

_____

What do you see as your child's most difficult problem in school? _____

_____

_____

What do you see as your child's most difficult problem at home? _____

_____

_____

Additional Comments or Concerns: _____

_____

_____

_____