Speech Therapy Intake Form

Patient Information

Name:

_____

Date of Birth:

Age:

_____

Name of Responsible Party:

_____

Relationship:

_____

Phone Number:

_____

Address:

_____

Has the patient had a speech evaluation before?:

_____

If yes, what diagnosis was given?:

_____

Current Concerns

(check all that apply)

- ☐ Articulation
- ☐ Fluency (stuttering)
- ☐ Language/Grammar
- ☐ Listening Comprehension
- ☐ Reading Comprehension

☐ Pragmatic/social communication skills

Medical History

Describe mother's pregnancy/labor:

Birth weight:

any complications during pregnancy/delivery?:

does the patient have any chronic health conditions or other diagnoses??:

Previously treated by:

Family History

who does the patient currently live with?:

Siblings and their ages:

Is there a family history for communication or learning disorders?:

Present Situation

Describe child's strengths:

describe child's weaknesses:

Additional

What do you hope to gain from this evaluation?: