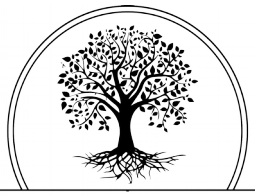

BLACK OAK THERAPY

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INTAKE FORM-CHILD

General Description of Speech/Language Concerns:_____

_____

_____

_____

Impact on Daily Life:_____

_____

Expectations from Therapy:_____

_____

Most Important Goals for Therapy:_____

_____

Social

Members of Household:_____

Daily Activities:_____

Hobbies:_____

Educational

School:_____Grade:_____Teacher:_____

Overall Academic Performance:_____

Overall Social Performance:_____

Medical

-Pregnancy:_____-Delivery:_____-Gestational Age:_____

-Medical Diagnosis:_____

-Genetic Testing:_____

-Injuries:_____

-Hospitalizations:_____

-Serious/Frequent Illnesses:_____

-Surgeries:_____

-Allergies:_____-Asthma:_____-Reflux:_____

-Tonsils/Adenoid removal_____-Ear Infections (ages):_____

-Hearing Condition:_____ -Vision:_____

-Eating Habits:_____

-Current Medications (purpose):_____

-Dental Condition:_____-Activity Level:_____-Sleep Condition:_____

Motor Development

Motor Milestones:

_____ Sat Alone _____Crawled _____Stood _____ Walked

_____ Toilet Trained _____Fed Self _____Dressed Self

Difficulty with the following activities:

Grasping Crayon/Pencil or Writing_____ Running or Jumping_____

Balance and Coordination for Walking_____ Riding a Bike_____

Overall Gross Motor Skills:_____

Overall Fine Motor Skills:_____

Speech and Language

Family History of: Speech Difficulties (speech sounds, fluency, etc.)_____

Language Difficulties_____

Learning Difficulties (reading, writing, etc.)_____

Hearing Issues_____

Developmental Milestones:

_____ Babbled _____ First Words _____ Put Two Words Together

_____ Spoke in Sentences_____ Asked Simple Questions _____Conversed

How does your child let you know what he/she wants? Please check all that apply.

_____Crying _____Looking at Objects _____Pointing at Objects _____Gestures

_____Making Sounds _____Touch/Grab _____Single Words _____2–3 Words _____Sentences

How well is your child understood by family?_____Strangers?_____

Does your child have difficulties pronouncing specific words? Explain._____

_____

Does your child ever stutter or "get stuck" when speaking? Explain._____

_____

Do you have concerns with your child's breathing or quality of voice (hoarse, breathy, etc.)?

_____

Does/Has your child had any feeding difficulties (chewing, swallowing, "picky eater", etc.)?

_____

Does your child have difficulty forming complete or grammatical sentences?_____

_____

Do you feel your child's vocabulary skills are delayed/atypical?_____

Describe your child's ability to follow directions (number or steps, complexity, need repetition)?

_____

Describe your child's reading, writing and reading comprehension._____

_____

Does your child have difficulty with social/conversational skills (eye contact, reading cues, topics, etc.)?_____

_____

Therapy History:

-Provider:
-Frequency/Length:
-Target:
-Effective Strategies:

-Provider:
-Frequency/Length:
-Target:
-Effective Strategies:

-Provider:
-Frequency/Length:
-Target:
-Effective Strategies:

-Provider:
-Frequency/Length:
-Target:
-Effective Strategies:

Progression of Difficulties:_____

Effects on Behavior/Personality:_____

Issues Worsen at Time/Place:_____

Awareness of Difficulties:_____

Educational

School:
-Name
-Dates Attended:
-Special Services:

School:
-Name
-Dates Attended:
-Special Services:

School:
-Name
-Dates Attended:
-Special Services:

School:
-Name
-Dates Attended:
-Special Services:

Does your child receive academic supports (RtI, learning centers, etc.), have classroom accommodations, or have an Individualized Education Program (IEP)? Describe:_____
_____
_____

Social/Behavioral
Temperament:_____

Behavior with Peers:_____

Attention Span:_____

Play:
-Ability:_____
-Preferences:_____

Behaviors:

_____Cooperative	_____Restless
_____Attentive	_____Poor Eye Contact
_____Willing to Try New Activities	_____Easily Distracted/Short Attention
_____Plays Alone	_____Destructive/Aggressive
_____Separation Difficulties	_____Withdrawn
_____Easily Frustrated/Impulsive	_____Inappropriate Behavior
_____Stubborn	_____Self-Injurious Behavior

Helpful Solutions for Behaviors:_____
_____
Additional Comments:_____
_____

Completed by:_____

Signature:_____

Relationship to Child:_____

Date:_____