Speech and Language Clinical Services Intake Form

Date Completed: __ / __ / __
Site Requested: __ Seattle __ Tacoma

Person Completing this Form

Name: _____ , _____ ___ Parent ___ Guardian ___ Other: _____
Last First

Are you authorized to consent for this individual's healthcare? ___Yes ___No

Client Information

Client Name: _____, _____

Date of Birth: _____ / _____ / _____

Please answer the following questions about the client's living situation:

A. Are the client's parents Divorced/Separated? _____ No _____ Yes
   1) If Divorced/Separated:
      Who is responsible for making medical decisions for the client? _____ Joint _____ Sole
      If sole custody, please specify which parent: _____
      With whom does the client reside? _____

B. Household 1: _____% time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to client of all other individuals in the home:
   _____
   _____

C. Household 2**:** _____ % time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to client of all other individuals in the home:
   _____
   _____

D. Are both parents aware of services being sought at the Autism Center? _____ No _____ Yes
   Does your client have a Guardian Ad Litem? _____ No _____ Yes
   If Yes, please provide their name: _____

E. Names and ages of any other siblings:
   _____
   _____

F. Primary Language: □ English □ Other: Specify _____
   Percent time client is exposed to non-English language(s): _____%

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Previous Evaluations/Assessments

Please list any school testing and/ or other evaluations of the Client's skills.

1. Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ___ No ___ Yes ___Unknown

   If yes, please provide the following information:
   A. Name: _____ Type of Specialist_____ Date of evaluation: _____
      Purpose of Evaluation / Services: _____
      Results of Evaluation: _____
      _____

   B. Name: _____ Type of Specialist_____ Date of evaluation: _____
      Purpose of Evaluation / Services: _____
      Results of Evaluation: _____
      _____

   C. Name: _____ Type of Specialist_____ Date of evaluation: _____
      Purpose of Evaluation / Services: _____
      Results of Evaluation: _____
      _____

2. Has the client ever had a hearing screening or evaluation?
   A. Name: _____ Type of Specialist_____ Date of evaluation: _____
      Purpose of Evaluation / Services: _____
      Results of Evaluation: _____
      _____

   B. Name: _____ Type of Specialist_____ Date of evaluation: _____
      Purpose of Evaluation / Services: _____
      Results of Evaluation: _____
      _____

Educational History

Please list the schools attended from most recent.

1. Is the client currently enrolled in school or Birth-3 Services? ___No ___Yes ___N/A
   School Name: _____ School District: _____
   Program or Grade level: _____

2. Please list any other schools that the Client has attended:
   A. School Name: _____ School District: _____
      Years of attendance: _____ Grade Levels: _____

   B. School Name: _____ School District: _____
      Years of attendance: _____ Grade Levels: _____

   C. School Name: _____ School District: _____
      Years of attendance: _____ Grade Levels: _____

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3. Is the client receiving or has the client received special services or accommodations at school? ____No ____Yes
If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan) _____
_____

Developmental History

1. Please indicate the age at which the following developmental milestones were reached:
   - Social Smile _____
   - Social Point or Gestures: _____
   - First Word _____
   - First Phrase _____

Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):
_____
_____
_____
_____

2. Dislikes (aversions):
_____
_____
_____
_____

3. Other important information:
_____
_____
_____

Concerns

1. Describe current language and communication abilities
_____
_____
_____

2. Reason for seeking Speech and Language Services [Please explain]:
_____
_____
_____
_____

3. Does the client exhibit verbal scripting? (Frequently repeats phrases from books, TV or environment) If yes, is this expression communicative/ an appropriate response to their environment?
_____
_____
_____
_____

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4. Does the client repeat words or phrases that are said to them (echolalia)?

_____
_____
_____
_____

5. Developmental and Medical Concerns [Please indicate by marking the box and explaining each domain]

☐Speech Delay/Disorder (e.g., Apraxia of Speech)

☐Language Delay/Disorder (Uses few words)

☐Medical Concerns (Epilepsy/Tics/etc.)

☐Vision Problems

☐History of Feeding Problems

☐Dietary/Allergies

☐Apnea/Breathing Problems

☐ Peer Interaction

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☐Play/Leisure

☐ Self-Help (Dressing/Toileting/Feeding/Etc.)

☐Cognitive Concerns

☐Executive Functioning (Organization/Flexibility/Attention)

☐Academics (Reading/Writing/Math)

☐Other

Additional Comments

_____
_____
_____
_____
_____

Evaluations/Assessment Reports

Please attach a copy of the client's reports (select attached)

☐Diagnostic Evaluation Report

☐IEP/IFSP/504 Plan

☐Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)

☐Other: _____

☐Other: _____

☐Other: _____

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Hours of Availability
Please mark the times you and the client **ARE** available for services.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					