Speech and Language Clinical Services Intake Form

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

Person Completing this Form

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

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:
   _____
   _____

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: _____

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

E. Primary Language: □ English □ Other: Specify _____
   Percent time client is exposed to non-English language(s): _____%
   Length of exposure to English: _____ Non-English language: _____
   Context of exposure (e.g., home, school) to English: _____ Non-English language: _____

F. Family History: Is there any known or suspected family history of any speech/language, behavior, learning, or physical development concerns? ___ No ___ Yes ___ Unsure

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Concerns

1. Describe current concerns regarding speech and language/communication abilities.
   _____
   _____
   _____

2. Are there concerns regarding:
   a. Understanding language: ___ Yes ___ No If yes, specify: _____
      _____
   b. Speaking/talking: ___ Yes ___ No If yes, specify: _____
      _____
   c. Social communication/peer interaction: ___ Yes ___ No If yes, specify: _____
      _____
   d. Using specific sounds (e.g., "r"): ___ Yes ___ No If yes, specify: _____
      _____
   e. Other: ___ Yes ___ No If yes, specify: _____
      _____

3. What do you hope to gain from a speech and language evaluation?
   _____
   _____
   _____

4. 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?
   _____
   _____
   _____

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

6. Does the client have problems with feeding/eating (e.g., a restricted diet, sensitivity to specific textures or types of food, being a picky eater)?
   _____
   _____
   _____

Medical History

1. Were there any complications during pregnancy, or during/after birth? ___ No ___ Yes
   If yes, please specify. _____
   _____

2. Has the client had any hospitalizations or surgeries, or other medical concerns? ___ No ___ Yes
   If yes, please specify. _____
   _____

3. Does the client take any medications? ___ No ___ Yes If yes, what: _____

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4. Does the client have any allergies or dietary restrictions? ___ No ___ Yes If yes, what: _____

5. Are there any concerns regarding hearing? ___ No ___ Yes
When and where was the client's hearing most recently tested? Date: _____ Where: _____

6. Are there any concerns regarding vision? ___ No ___ Yes When
and where was the client's vision most recently tested? Date: _____ Where: _____

Speech and Language Developmental History and Current Skills

1. Please indicate the age at which the following developmental milestones were reached:
   a. Babbling: _____
   b. First words other than mama or dada: _____
   c. Fist word combinations/phrases: _____

2. Does the client currently demonstrate the following skills:

a. Respond to his/her name: ___ Always ___ Sometimes ___ Never
b. Follow directions: ___ None ___ 1-step ___ 2-step Example: _____

c. Answer questions: ___ Choice ___ Yes/No ___ "Wh" (e.g., what, where, who)
d. Communicate using primarily: ___ Body movements and gestures ___ Single words ___ Phrases and sentences ___
Other (e.g., AAC device) (please specify): _____
e. How many words does the client use? ___ 0-20 ___ 20-50 ___ 50-100 ___ 100+

f. What percentage of the client's speech do <u>you</u> understand? ___% What percentage do <u>others</u> understand? ___%

g. How does the client interact (e.g., playing, talking) with peers? _____
_____

If appropriate for your child, complete the following questions:

1. Does your child take at least 5 conversational turns (child + communication partner = 1 turn) with preferred topics? ___ Yes ___ No If not, how many turns: _____

2. Does your child retain employment or volunteer consistently (e.g., at the library, Goodwill)? ___ Yes ___ No
If so, please describe work and/or volunteer responsibilities:
_____
_____

3. Are there communication or other difficulties that impede his/her work or volunteer responsibilities?
___ Yes ___ No If yes, please describe:
_____
_____

4. Does the client exhibit difficulties identifying emotions or perspective taking of others? ___ Yes ___ No
If yes, please describe:
_____
_____

5. Does the client maintain friendships with similar aged peers? ___ Yes ___ No

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Where? __ School/Work __ Outside of Structured Settings __ Both
Please describe these relationships:

_____
_____

Previous Evaluations and Treatment

1. Are there any other medical or mental health disorders that the client has been diagnosed with or in the process of being diagnosed? (e.g., ADHD, ODD, Down Syndrome, GI issues)
   If so, please list below, and include year diagnosed:

_____
_____
_____
_____

2. Has the client ever been evaluated or received treatment from a speech therapist, occupational therapist, ABA provider, psychologist, physical therapist, special educator, or other therapist? __ No __ Yes

   If yes, please provide the following information:

   A. Name: _____ Type of specialist: _____
   Date(s) of evaluation/treatment: _____
   Purpose and results of evaluation/treatment: _____
   _____
   _____

   B. Name: _____ Type of specialist: _____
   Date(s) of evaluation/treatment: _____
   Purpose and results of evaluation/treatment: _____
   _____
   _____

   C. Name: _____ Type of specialist: _____
   Date(s) of evaluation/treatment: _____
   Purpose and results of evaluation/treatment: _____
   _____
   _____

Educational History

7. Is the client currently enrolled in school or Birth-3 Services? __ No __ Yes __ N/A
   School Name: _____ School District: _____
   Program or Grade level: _____

8. 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: _____

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Years of attendance: _____ Grade Levels: _____

9. Is the client receiving or has the client received special services or accommodations at school? ____ No ____ Yes
   A. If yes, please explain what type (e.g., IEP, IFSP, 504 Plan) and what type(s) of services received (e.g., communication, cognitive, social/emotional, fine/gross motor, reading, math).

_____
_____
_____

Client's Interests

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

_____
_____
_____
_____

2. Dislikes (aversions):

_____
_____
_____
_____

3. Other important information:

_____
_____
_____
_____

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: _____

Hours of Availability

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

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	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					