



# Client Intake Form

Date: \_\_\_\_\_

Client's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ **M** **F** Grade: \_\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_

Parent: \_\_\_\_\_ Parent: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Preferred method of contact:  Phone  Alt Phone  Email

**Regional Center Client:** NO YES If so, have you spoken to your case manager? Yes Not yet

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

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## Current Services

Describe your major concerns regarding your child (be specific): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pediatrician: \_\_\_\_\_ Last seen: \_\_\_\_\_

Diagnosis (if any): \_\_\_\_\_

SLP services: (therapist/frequency) \_\_\_\_\_

Addressing: \_\_\_\_\_

OT services: (therapist/frequency) \_\_\_\_\_

Addressing: \_\_\_\_\_

Psychological services: (therapist/frequency) \_\_\_\_\_

Addressing: \_\_\_\_\_

Other: \_\_\_\_\_

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## **Family History**

Language(s) spoken in the home: \_\_\_\_\_

**Child is...** Biological \_\_\_\_\_ Foster \_\_\_\_\_ Adopted \_\_\_\_\_ at what age \_\_\_\_\_

### **Child resides with:**

Biological Mother	_____	Biological Father	_____
Adoptive Mother	_____	Adoptive Father	_____
Foster Mother	_____	Foster Father	_____
Other (specify)	_____		

### **Siblings**

	Name	Age	Medical, social, academic concerns
1.	_____		
2.	_____		
3.	_____		

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## **Birth History**

Pregnancy/Labor: \_\_\_\_\_ Normal/No Complications  
\_\_\_\_\_ Complications - briefly explain: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Post-Delivery: \_\_\_\_\_ Normal/No Complications while in hospital  
\_\_\_\_\_ Complications - briefly explain: \_\_\_\_\_  
\_\_\_\_\_ Weak Suck \_\_\_\_\_ Vomiting \_\_\_\_\_ Diarrhea \_\_\_\_\_ Infections \_\_\_\_\_ Low Tone/neurological  
\_\_\_\_\_ # of days baby was in hospital after delivery

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## **Medical History** (check all that apply)

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Chronic Colds/respiratory infections | <input type="checkbox"/> Temporary Hearing Loss     | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Chronic Ear Infections               | <input type="checkbox"/> Hearing Impairment         | <input type="checkbox"/> Allergies   |
| <input type="checkbox"/> Cerebral Palsy                       | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> High Fever  |
| <input type="checkbox"/> Head Trauma                          | <input type="checkbox"/> Eye Problems               | <input type="checkbox"/> Tonsillitis |

Is your child taking any medication? \_\_\_\_\_

Does your child have any food allergies? \_\_\_\_\_  
\_\_\_\_\_

Is your child on any special diet or dietary restrictions? \_\_\_\_\_  
\_\_\_\_\_

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**Development**

At what age did you first become concerned about your child's speech, language or communication skills and why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The following section is to be completed if your child is four years of age or younger**

*Birth to 2 Years*

Please check all of the following that applied to your child during his/her first two years.

- Separation from parents for a long time
- Frequent hospitalization
- Resistance to cuddling
- Difficult to calm
- Colicky
- Restless
- Inactive
- Difficulty eating
- Accident prone
- Avoidance of eye contact
- Nonresponsive when spoken to
- Unusual play methods
- Failure to develop gestures (bye-bye)
- Failure to point or request
- Failure to coo or babble
- Difficulty sharing
- Difficulty sleeping

**Developmental Milestones**

Did your child reach the following milestone at the typical age?

*Milestone (Typical Age)*

*if no, at what age*

<b>Pointed</b> (6-8months)	Y	N	_____
<b>Smiled</b> (6-8mo)	Y	N	_____
<b>Sat w/o support</b> (6-8 mo)	Y	N	_____
<b>Crawled</b> (9-11mo)	Y	N	_____
<b>Walked w/assistance</b> (12-15mo)	Y	N	_____
<b>Spoke first words</b> (12mo)	Y	N	_____
<b>Spoke in phrases</b> (18mo)	Y	N	_____
<b>Spoke in sentences</b> (18mo)	Y	N	_____
<b>Self fed using finger food</b> (18mo)	Y	N	_____
<b>Self fed using cup/spoon</b> (12-16)	Y	N	_____
<b>Potty trained/by day</b> (24-36)	Y	N	_____
<b>Dressed self</b> (24-36)	Y	N	_____

Does your child (please check all that apply):

- Repeat sounds, words, or phrases over and over
- Follow simple directions
- Retrieve/point to common objects when requested
- Understand what you are saying
- Respond correctly to who/what/when questions
- Respond correctly to Yes/No questions

How does your child currently communicate?

- Body Language
- Sounds (vowels, gurgling)
- Words (shoe, doggy)
- 2 to 4 word sentences
- Sentences longer than 4 words
- Other \_\_\_\_\_

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## **Educational History**

Current School: \_\_\_\_\_ District: \_\_\_\_\_

- Regular Education
- Special Education
- Aide \_\_\_\_\_ % of school day

How is your child doing academically (or pre-academically)?  Excellent  Satisfactory  Poor

Has his/her teacher reported any concerns to you? (please describe) \_\_\_\_\_

\_\_\_\_\_

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In order to assist the therapist get a complete profile of your child's strengths and weaknesses, please check off any and all areas which you feel may **currently** apply to your child:

### **Auditory Processing**

- Does not listen carefully to directions – often need to repeat instructions
- Sometimes misunderstands what is said
- Needs extra time to respond to questions
- Background noise makes following verbal instructions even more difficult
- Says "huh" or "what" in response to questions
- Does not respond to name when called

### **Listening:**

- Has trouble paying attention
- Has trouble following spoken directions
- Has trouble remembering things people say
- Has trouble understanding what people are saying
- Has to ask people to repeat what they have said
- Has trouble understanding the meaning of words
- Has trouble understanding new ideas
- Has trouble looking at people when talking or listening
- Has trouble understanding facial expressions, gestures, or body language

### **Attention:**

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- Often has difficulty sustaining attention in tasks or play activities in school and at home
- Has difficulty organizing tasks and activities
- Often loses things necessary for tasks and activities (e.g. toys, school assignments, pencils, books, or tools)
- Fidgets with hands or feet or squirms in seat
- Leaves seat in classroom or in other situations in which remaining seated is expected
- Easily distracted
- Often blurts out answers before the questions have been completed

- Has difficulty awaiting turn
- Daydreams and/or is inattentive

### **Speaking:**

- Has trouble answering questions people ask
- Has trouble answering questions as quickly as other students
- Has trouble asking for help when needed
- Has trouble asking questions
- Has trouble using a variety of vocabulary words when talking
- Has trouble expressing thoughts
- Has trouble describing things to people
- Has trouble getting to the point when talking
- Has trouble putting events in the right order when telling stories or talking about things that happened
- Uses poor grammar when talking
- Has trouble using complete sentences when talking
- Talks in short, choppy sentences
- Has trouble expanding an answer or providing details when talking
- Has trouble having a conversation with someone
- Has trouble talking with a group of people
- Has trouble saying something another way when someone doesn't understand
- Gets upset when people don't understand

### **Word Retrieval**

- Knows the word (s)he wants to say, but cannot think of it
- Has difficulty remembering the names of people, places, objects that he/she knows.
- Substitutes words with a similar word or by describing the word by category, function, or what it looks like
- There is sometimes a long delay when he/she cannot think of the word
- Makes false starts and revisions when relating an experience (e.g. "we were...Bob and I went to the game")
- Uses time fillers when trying to think of a word (e.g., um..er..um..computer)
- Gives too much information, includes irrelevancies

### **The following may or may not be applicable to your child**

- Not applicable

### **Reading:**

- Has trouble sounding out words with reading
- Has trouble understanding what was read
- Has trouble explaining what was read
- Has trouble identifying the main ideas
- Has trouble remembering details
- Has trouble following written directions

### **Writing:**

- Has trouble writing down thoughts
- Uses poor grammar when writing
- Has trouble writing complete sentences
- Writes short, choppy sentences
- Has trouble expanding an answer or providing details when writing
- Has trouble putting words in the right order when writing sentences

## **Occupational Therapy/ Sensory Integration**

### **Tactile (Touch):**

Does child....	Dislike being held or cuddled?	Yes	No
	Intrude in others personal space?	Yes	No
	Seems easily irritated or enraged?	Yes	No
	Have a strong need to touch objects and people	Yes	No
	Pinch, bite or hurts him/herself or others?	Yes	No
	Frequently bumps or pushes others?	Yes	No
	Has unusually high pain tolerance?	Yes	No
	Dislike the feeling of clothing/textures?	Yes	No
	Over or under dresses for the temperature?	Yes	No
	Seem overly sensitive to some food textures?	Yes	No
	Dislike having hair washed/cut or nails cut?	Yes	No
	Dislike the feeling of sand, mud, and clay on hands/feet?	Yes	No
	Often seems unaware of minor cuts, bruises, etc?	Yes	No
	Seem unaware of food/liquid left on lips?	Yes	No
Able to tell what is in his/her hand without looking?	Yes	No	
Comments:			

### **Vestibular (Movement) and Proprioceptive:**

Does child....	Seeks out rough housing, jumping or crashing games?	Yes	No
	Jump off tall furniture, climbs trees without regard to safety?	Yes	No
	Like being tossed in the air?	Yes	No
	Like fast spinning carnival rides?	Yes	No
	Plays on swings or slides more than other children?	Yes	No
	Spin or whirls more than other children?	Yes	No
	Seem to be constantly on the move or driven by a motor?	Yes	No
	Gets nauseous, carsick and/or vomit easily?	Yes	No
	Have fear in space (stairs, shaky bridges, heights)?	Yes	No
	Lose balance easily?	Yes	No
	Walks on toes (not flat feet)?	Yes	No
	Has a difficult time sitting still (watching a movie, sitting at desk)?	Yes	No
	Enjoy being upside down (somersaults, hanging from legs)?	Yes	No
	Prefer to be sedentary (on computer/TV) than play outside?	Yes	No

Comments:	
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**Visual:**

Does child....	Have a diagnosed vision problem?	Yes	No
	Have trouble tracking objects with eyes?	Yes	No
	Avoid eye contact with others?	Yes	No
	Have trouble copying words from the board?	Yes	No
	Have a difficult time putting together puzzles?	Yes	No
	Make reversals when copying or reading?	Yes	No
	Become frustrated finding something in a cluttered drawer?	Yes	No
	Have trouble discriminating shapes, colors correctly?	Yes	No
	Squint often (when reading or outside in sunlight)?	Yes	No
Comments:			

**Taste and Smell:**

Does child....	Chew on non-food items (pencils, shirt, hair)?	Yes	No
	Demonstrate being an extremely picky eater?	Yes	No
	Have trouble eating different textured foods?	Yes	No
	Sensitive or insensitive to noxious smells/tastes?	Yes	No
	Mouth, taste or smell objects when playing with them?	Yes	No
	Prefer spicy, sour bitter food flavors?	Yes	No
Comments:			

**Auditory (Sound):**

Does child....	Have a diagnosed hearing problem?	Yes	No
	Have PE tubes in his/her ears?	Yes	No
	Have frequent ear infections?	Yes	No

	Show difficulty/bothered by loud sounds?	Yes	No
	Respond negatively to unexpected noises?	Yes	No
	Bothered by background sounds such as the refrigerator, fluorescent light bulbs, fans, when trying to concentrate?	Yes	No
	Appear deaf at times (i.e. doesn't respond to name) although hearing is intact?	Yes	No
	Like to play or make music at loud volumes?	Yes	No
	Like to sing and/or dance to music?	Yes	No
	Have difficulty if 2 or 3 step instructions are given at once?	Yes	No
	Talk excessively/not willing to wait their turn?	Yes	No
	Have a delay in speech development?	Yes	No
Comments:			

**Muscle Tone:**

Does child....	Big for his/her age?	Yes	No
	Have any diagnosed muscle problems?	Yes	No
	Have flat feet?	Yes	No
	Slouch when sitting on floor/chair?	Yes	No
	Get tired easily playing or writing?	Yes	No
	Seem generally weak compared to other kids?	Yes	No
	Keep mouth open when breathing?	Yes	No
Comments:			

**Coordination:**

Does child....	Sit, stand or walk late?	Yes	No
	Was creeping or crawling phase unusually prolonged?	Yes	No
	Was creeping and crawling phase almost entirely omitted?	Yes	No
	Have difficulty with sequential tasks; dressing, buttoning, zipping?	Yes	No
	Have difficulty playing on playground equipment?	Yes	No
	Have difficulty learning to hold a pencil or crayon in a 3-point position?	Yes	No

	Have poor ball skills for P.E. type activities?	Yes	No
	Seem clumsy, awkward?	Yes	No
	Bump into furniture, people a lot?	Yes	No
	Uses a dominant hand?	Yes	No
	If yes, which hand is dominant?	Right	Left
	Have poor handwriting?	Yes	No
	Have trouble using both hands together easily (opening milk carton cutting, etc)?	Yes	No
	Dislikes sports, gym etc?	Yes	No
	Able to ride a bike (tricycle, big wheel)?	Yes	No
	Able to tie shoelaces?	Yes	No
Comments:			

**Behavior/Temperament:**

Is child...	Quiet, calm, relaxed, patient?	Yes	No
	Active, outgoing, enthusiastic?	Yes	No
	Intense, demanding?	Yes	No
	Seem hyperactive, in perpetual motion all the time?	Yes	No
	Upset by transitions/unexpected changes?	Yes	No
	Exhibit frequent temper tantrums?	Yes	No
	Become easily frustrated?	Yes	No
	Passive, quiet, withdrawn?	Yes	No
	Rigid, set in his/her ways?	Yes	No
	Regular sleep patterns?	Yes	No
	Difficult to get to sleep?	Yes	No
	Destructive with toys?	Yes	No
	Short attention span?	Yes	No
	Very cautious/afraid to try new things?	Yes	No
	Impulsive or acts without thinking?	Yes	No
	Have difficulty or very cautious when trying new things?	Yes	No
	Have nervous habits, tics or often appear anxious?	Yes	No
	Nearly impossible to take to the movies, church/temple or other settings that don't allow them to move around?	Yes	No
Have trouble keeping personal space neat/organized (desk, room)?	Yes	No	

Comments:	
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**Social Learning**

Please rate (**Good, Fair, Poor**)

\_\_\_\_\_ Eye Contact    \_\_\_\_\_ Greetings    \_\_\_\_\_ Play    \_\_\_\_\_ Organizational Skills    \_\_\_\_\_ Story telling

Please list strengths and weaknesses your child has in the area of social skills.

**Strengths:** \_\_\_\_\_

**Challenges:** \_\_\_\_\_

Please list three **goals** you have for your child in the area of social skills.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

What are some of your child's **interests/activities** within and out of school?

\_\_\_\_\_

\_\_\_\_\_

Are there any situations, relevant to our group, which may **upset or agitate** your child?

\_\_\_\_\_

\_\_\_\_\_

Additional Concerns and Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_