Add Therapy Center

Speech and Language Therapy Intake Form

Physicans Name: ___________________________________
Phone: ____
Email: ____

Describe your child's speech/language problem in your own words:

____

____

At what age was this problem first noticed? ____

Who first noticed the problem? ____

How has the problem changed since that time? ____

____

____

Does your child use speech? ☐ Occasionally ☐ Never ☐ Frequently

What is the current communication style(s) used by your child? Check all that apply:

- ☐ Non-word Vocalizations
- ☐ Single Words
- ☐ Words and Gestures
- ☐ Short Phrases
- ☐ Word Combinations
- ☐ Full Sentences
- ☐ Gestures and/or Pointing Only

Estimate size of expressive vocabulary (number of words child spontaneously uses): ________________________

Is correct word order used in sentences/phrases? ☐ Yes ☐ No

Do you have difficulty understanding your child? ☐ Yes ☐ No

Do other people have difficulty understanding your child? ☐ Yes ☐ No

Does your child feel frustrated by an inability to communicate? ☐ Yes ☐ No

Do you think your child stutters? ☐ Yes ☐ No

How well does your child understand what is being said to him/her (ability to follow directions and understand meaning of words)? ____

____

Has your child had any problems learning to read? ☐ Yes ☐ No

Learning to write? ☐ Yes ☐ No

If yes, please explain: ____

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