Speech & Language A to Z LLC

Intake & Background Information

Client's Name: _____ Date: _____
Client's DOB: _____ Client's Gender: _____
Insurance Provider: _____

PARENT/CUSTODIAN CONTACT INFORMATION

Parent/Caregiver's Name: _____ Relationship: _____
DOB: _____ Insurance Provider: _____
Email: _____ Mobile: _____
Work: _____ Home: _____
Preferred method of contact: _____

Parent/Caregiver's Name: _____ Relationship: _____
DOB: _____ Insurance Provider: _____
Email: _____ Mobile: _____
Work: _____ Home: _____
Preferred method of contact: _____

INSURANCE

Group Number: _____ Member Number: _____
Referral Source: _____ Primary Physician: _____
Primary Physician's Number: _____

COMMUNICATION

Please describe the client's interests:

Describe the client's strengths:

Please describe the client's current communication (gestures or words, length of sentences, requests, etc.):

Please describe the client's signs of frustration:

How intelligible is the client? Can unfamiliar listeners understand him/her?

Does the client have difficulty understanding directions?

Please describe how the client communicates and participates during social situations (appropriate eye contact, tone of voice, volume, etc.):

List your communication goals for the client:
1.

2.

3.

4.

5.

Please describe any other areas of concern:

DAILY LIFE

Please describe a typical day for the client:

In what environments does the client communicate? (school, home, daycare, etc.)

Family Members
Who does the client live with?

Name	Relationship	Age

DEVELOPMENTAL & HEALTH HISTORY

Milestones

At what age did the client…

Sit: _____
Crawl: _____
Walk: _____
Finish toilet training: _____

Use 1st words: _____
Use 2-word phrases: _____
Use 3-5 word phrases: _____
Follow simple directions: _____

Medical History/Illnesses

Current diagnoses, age of diagnosis, and diagnosis source (e.g., school/doctor/SLP/UNM CDD/clinic, etc.):

Please list any communication-related diagnoses of relatives:
(examples: Articulation/Phonological Disorder, Stuttering, Autism Spectrum Disorder)

Please list or describe any recent/current illness or medical concerns:

Please describe any significant medical events/illnesses:

How many ear infections has the client had?
Was the client's hearing tested at birth?
Approximate date of most recent hearing test:
Does the client have tubes in his/her ears?

Please list the client's current medications & conditions for each:
Click here to enter text.

Please list any therapy the client receives or received in the past:

Location/Provider (e.g., APS)	**Type of service** (e.g., OT, PT, SLP, behavioral, etc.)	**Reason for intervention** (e.g., articulation, language, etc.)	**Dates of Service**