New Client Intake

The information provided will be very helpful in treating your child as well as the insurance process. Please fill out completely or to the best of your knowledge.

Date:_____
How did you hear about us?_____

General Information

Your Name: _____Relation to client _____

Home Phone: _____ Cell Phone: _____

Child's Legal Name (Last, First, Middle): _____

Child's DOB (MM/DD/YYYY): _____ Gender: **Male** **Female**
Current Grade:_____

Child's Primary Residence (Street Name, Building and/or Apt. #, City, State, ZIP):

_____

_____

What is your child's ethnic/cultural background? _____

List any legal issues involving your child (divorce, custody issues, etc):
_____

Primary Contact Information

Father's/Mother's/Guardian's Name (Last, First, Middle): _____

Living with Child? **Yes** **No**

Primary Residence (If Different from Student's Address):
_____

Home Phone: _____Work Phone: _____Cell Phone: _____
Driver's License (No. and State): _____ Email: _____

What is your preferred method of contact (email, phone):
_____

Father's/Mother's/Guardian's Name (Last, First, Middle):_____

Living with Child? **Yes** **No**

Primary Residence (If Different from Student's Address):

_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Driver's License (No. and State): _____Email: _____

List Siblings (Brother/Sister, Name, Age):_____

_____

Who lives in child's main household?

_____

Behavior

What behavior challenges is your child having?

_____

_____

How have these behaviors affected the child and family members?_____

Has your child ever threatened/attempted to harm self or others? **Yes** **No**
Explain: _____

Does your child elope (run away)? **Yes** **No**

What do you and your spouse/partner do when your child misbehaves?
You: _____

Spouse/Partner:

_____

Health History

Pediatrician: _____Phone number: _____

Please list child's main diagnosis(es) ex. Autism:

_____

Diagnosing physician and phone number: _____

List any medications and/or supplements your child is on: _____

_____

List all therapies and/or treatments child is currently receiving: _____

_____

List therapies/treatments child received in the **PAST**:_____

Please identify if child has had the following diseases by writing the age he/she had the disease on the line: Chickenpox: _____Measles: _____Mumps: _____
Age Age Age

Are all immunizations up-to-date? **Yes** **No**
If "no", list which ones:

_____

Does this child have an ongoing health concern? (Asthma, Diabetes, Etc.) **Yes** **No**
If "yes", please describe:

_____

Does this child have any allergies (food, medication, etc)? : **Yes** **No**
If "yes", please list:

_____

Has the allergy required emergency treatment? **Yes** **No**
If "yes", please explain:

_____

Does your child present with a hearing loss? **Yes** **No**
Has your child ever had ear infections? **Yes** **No**

If yes, how many ear infections and at what age? How were they treated?

_____

If your child has not been previously diagnosed with a hearing loss, do you suspect a hearing problem? **Yes** **No**

Circle all that apply:

Asthma or Lung Problems
Depression/Mental Health Issue
Diabetes/Hepatitis
Ear/Nose/Throat
Epilepsy/Seizures
Fracture/Dislocation/Strain
Hearing Aid/Orthopedic Braces
Head Injury
Heart Problems
Kidney/Urinary Problems
Ulcers/Digestive
Skin/Toes
Surgery
Other (ADHD,AIDS, etc.)
_____

For each condition circled above, please indicate if it is past or present condition, the treating physician's name and phone number, and current medication requirements and purpose:

_____

_____

Is there a history of any hospitalizations, significant injuries or surgery? **Yes No**
If "yes", please describe:

_____

Family History (parents, grandparents, siblings, living or deceased):

_____

Describe child's usual energy/activity level:

_____

Developmental History

Were there any issues during pregnancy, labor and/or delivery for this child? **Yes** **No**

Describe child as an infant/toddler, up to 24 months (cheerful, fussy, cuddly, withdrawn, etc):

_____

Age child first sat up: _____ Took steps: _____ Spoke words: _____
Age first spoke in sentences: _____ Age toilet-trained during day: _____ Night: _____
Problem now? _____ Age dressed self: _____ Tied shoe-laces: _____ Rode 2-wheel bike: _____

Speech and Language Development History

Child said first words between the ages of 12 and 18 months? **Yes** **No**
Child used two words together (i.e., "Mommy go," or "Want drink") by 24 moths? **Yes** **No**
During the first year, was your child unusually quiet and/or made few sounds other than crying? **Yes** **No**
How much does the child talk at home?_____ Average _____ None _____ A few words
Does the child use gestures with words? **Yes** **No**
Does the child mainly use gestures? **Yes** **No**
Are there languages other than English spoken in the home? **Yes** **No**
If yes, what language(s)? _____
Does the child speak or understand other languages? **Yes** **No**
If yes, what language(s)? _____
How well does the family understand the child's speech?

_____ Easily understood
_____ Understood if the listener knows the topic
_____ Words understood now and then
_____ Completely unintelligible
_____ Gestures understood

Did your child's speech/language learning ever seem to stop? **Yes** **No**
If yes, please explain:_____

Does your child have difficulty understanding directions or conversations? **Yes** **No**

Does your child respond to the following?

His/Her Name	**Yes**	**No**
Verbal Instructions	**Yes**	**No**
Instructions with gestures	**Yes**	**No**
Gestures Alone	**Yes**	**No**
Soft Noises	**Yes**	**No**
Loud Noises	**Yes**	**No**

How do you communicate with your child?

_____

_____

How does your child make his/her needs known to you?

_____

_____

Please describe your main concerns regarding your child's speech and language?

_____

_____

School Information (if applicable)

School: _____ Address: _____

Phone: _____Teacher: _____ Counselor: _____

List any known learning disabilities your child has:

_____

Is your child receiving Special Education services at school? **Yes** **No**
If "yes", then please complete the following:
Circle all that apply:

Content Mastery/Resource Room
Counseling
Speech Therapy
Occupational/Physical Therapy
Behavior Unit
Other:_____

If "no", then please complete the following:
Has child ever received Special Education services? **Yes** **No**
If "yes", please specify school name and year:_____

Describe effort/attitude toward school:

_____

Describe academic performance:

Describe behavior in school:

When did school performance/behavior change?

Why do you think it changed?

Will you need IEP review or ARD advocacy? **Yes** **No**