Client Intake Questionnaire

* Required

1. Email *

2. Child's Full Name *

3. Child's Date of Birth *

Example: January 7, 2019

4. Parent/Guardian Full Name *

5. Parent/Guardian Phone Number *

6. Parent/Guardian E-mail *

7. Parent/Guardian Full Name

8. Parent/Guardian Phone Number

9. Parent/Guardian E-mail

10. Home Address *

11. Where did you hear about Speak With Me RI, LLC?

- [ ] Client referral
- [ ] Website
- [ ] Facebook or Instagram
- [ ] Professional (e.g., doctor, psychologist, teacher)
- [ ] Please provide name: _____

12. Child's School Name and Grade

13. Does your child have an IEP or 504 Plan at their school?

- [ ] Yes
- [ ] No
- [ ] Other: _____

14. Does your child have any diagnoses (e.g., Autism, ADHD, Anxiety, Dyslexia, etc)?

15. What are your speech and language concerns for your child? *

16. Child's Physician Name, Practice Name, and Phone

17. Does your child have siblings? If yes, please list their names and ages.

18. What language is spoken in the home?

19. Was your child responsive as an infant? (e.g., smile or cry appropriately)

20. If your child is verbal, when did they first use single words?

21. If your child is verbal, when did they first use phrases?

22. If your child is verbal, when did they first use sentences?

23. Does your child understand familiar routine spoken directions at home?

24. Are your child's needs/wants anticipated before he expresses them?

25. At what time were you first concerned about your child's speech/hearing difficulties?

26. Please give an example of what your child would do or say if they wanted a snack.

27. Can your child be understood by (please check all that apply):

Check all that apply.

- [ ] Parents
- [ ] Relatives
- [ ] Peers

28. Does any other member of the family have a speech or hearing problem? If yes, please briefly describe

29. Has your child ever been seen for a speech/hearing evaluation or examined by anyone other than a physician? If yes, please state where and when:

30. Has your child ever received speech, language, physical, or occupational therapy? If yes, please state where and when:

31. Has your child's hearing been screened? If so, when and what was the result

32. Has your child been seen by the eye doctor? If so when and what was the result?

Birth History

33. Were there any conditions during pregnancy? If yes, please describe (e.g., maternal health, gestational diabetes, fetal health, medical care, illness, etc.):

34. When did you deliver--at how many weeks (e.g., 38 weeks, 39 weeks)?

35. What type of birth?

Mark only one oval.

- Vaginal
- Caesarean

36. Were there any birth complications? If yes, please describe.

Developmental History

37. When did your child first roll?

38. When did your child first sit alone?

39. When did your child begin crawling?

40. When did your child begin walking?

41. If your child is toilet trained, when did they accomplish this?

42. Does your child sleep well at night?

- [ ] Yes
- [ ] No
- [ ] If no, Please describe:

43. Does your child notice their communication difficulties? If yes, please describe.

44. Please describe your child's temperament and personality.

45. Does your child play well with others? If no, please describe.

46. Do you consider your child well coordinated or do they have some troubles controlling their body in space?

47. Did your child ever have any feeding difficulties? If yes, please describe.

48. What is something your child really enjoys or is very good at?

Medical History

49. Any serious illness? If yes, please describe.

50. History of seizures? If yes, please describe.

51. Any serious accidents? If yes, please describe.

52. Any previous surgeries? If yes, please describe what and when.

53. Has your child had their tonsils and/or adenoids removed? If yes, when?

54. Does your child have frequent colds, throat infections or ear infections? If yes please describe.

55. How many ear infections has your child had?

56. Has your child had tubes inserted to help with ear infections? If yes, when and who was the ENT/Audiologist?

57. Does your child have allergies? If yes, please describe.

58. Is your child currently on medication? If yes, please describe.

Educational Concerns

59. What academic areas do you have concerns in for your child? Please check all that apply.

Check all that apply.

- [ ] Reading
- [ ] Letter Recognition
- [ ] Phonemic Awareness
- [ ] Spelling
- [ ] Writing
- [ ] Vocabulary
- [ ] Reading Comprehension
- [ ] Defining Words
- [ ] Recalling Information
- [ ] Following Directions
- [ ] Social Interaction with Peers

Other: [ ]