Shelly Ransom, M.S., CCC-SLP

Speech Language Pathologist

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Intake Form

This form asks several questions that may take more space to answer than is provided. Rest assured that during the phone consultation, you will have time to provide more information in order to give the most accurate picture of your child's needs.

Client Information

Date	Completed by (Name)	Relationship to Child

Child's Full Name	Sex/Gender ID

Age	Date of Birth	Grade

School

Primary Language	Language(s) Spoken at Home

Home Address	Best way to Communicate ?

Parent Name	Parent Name

Email & Cell	Email & Cell

Sibling(s)?	Sibling(s) names & ages

Briefly describe the problem(s)/concern(s). (e.g., language, articulation, fluency, social communication, other)

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Does your child have a diagnosis? When did s/he receive the diagnosis or how long has the problem above existed?

Medical History

Please describe any medical diagnoses, conditions, hospitalizations, or injuries your child has had. List Medications too.
Labor and Delivery – please list any complications, birth weight, and/or, difficulties experienced at birth.
Please note results of latest hearing and vision screenings and indicate any past or current problems with vision and hearing.
Has your child ever received therapeutic services? (SLP/OT/PT/Psych) If yes, please list and include diagnoses given.
Please note any additional medical or psychiatric information not already provided.
Did your child reach developmental milestones on time (first words, crawling, walking, etc.)?

School/Educational History

List all schools (including current school) attended and years of attendance.

Does child receive Special Education services? Please note whether your child has an Individualized Education Plan (IEP) or Section 504 Plan, the primary classification, and services received.

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Please describe any current school difficulties.
Has your child ever missed an extended amount of school? If yes, please explain.

Has your child had any of the following evaluations performed in school or privately? If so, please provide copies of prior evaluations.

	Name of Evaluator	Date of Evaluation	Findings
Psychology			
Speech and Language			
Occupational Therapy			
Audiology			
Physical Therapy			
Neurology			
Other			

Please discuss any additional therapeutic services or evaluations received that have not already been reported.
Briefly describe your child's play.
Does your child have difficulty sleeping? If so, describe.
Does your child currently or have a history of difficulty feeding? Picky eating?

Form Completed by (Please Print)	Relationship to Child	Date

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