AUBIN APHASIA
Speech & Language Center

330 S Madison Ave Suite 106

Bainbridge Island WA 98110

(206) 451-4308

Child Intake Form

Date : _____

Patient Information

Patient Name (first, middle, last): _____

Nickname: _____ Birthdate: _____

Gender : _____ **Pronouns: _____**

Child lives with: _____

_____

Birth Parents/ Foster Parents/ One Parent /Adoptive Parents /Parent and Stepparent /Switches between parents

Is there another language other than English spoken in the family? ☐ Yes ☐ No If yes, which one? _____

Other children in the family

Name Age Gender Grade Speech/Hearing Problems

_____

_____

_____

Referral

Referring Physician : _____

Physician Phone: _____ Fax: _____

Were you referred to our office? By Whom? _____

Doctor Friend Insurance School Therapist Website Other

Insurance Information

Please provide a copy of both sides of your insurance card. If you have more than one form of insurance, please provide us with a copy of the front and back of all your cards.

Please also provide a copy or the picture identification of the primary insurance holder.

Cash Pay Information

You/your family has the right to be provided with a good-faith estimate of the costs of services. AASLC will provide that good-faith estimate either at the time the service is scheduled or upon your request. We will need to complete a formal Evaluation to determine the approximate duration of your plan of care.

Describe the primary reason you are seeking speech and language therapy.

_____

_____

_____

Medical History

Has your child had any of the following? Please circle.

❑ Adenoidectomy

❑ Allergies

❑ Breathing Difficulties

❑ Ear Infections How often? _____

❑ Ear Tubes

❑ Encephalitis

❑ Head Injury

❑ High Fevers

❑ Seizures

❑ Sleeping difficulties

❑ Thumb/finger sucking habit

❑ Tonsillectomy

❑ Tonsillitis

❑ Vision Problems

Please list any medications your child takes regularly:

_____

_____

_____

Other serious injury/surgery:_____

_____

Is your child currently (or recently) under a physician's care? Yes No If yes, please describe: _____

_____

What do you see as your child's most difficult problem in the home?

_____

Developmental History

Please tell me the approximate age your child achieved the following developmental milestones (months):

Sat alone _____

Babbled _____

Grasped crayon/pencil _____

Said first word _____

Put two words together _____

Spoke in short sentences _____

Walked _____

Toilet trained _____

Does your child…

❏ Brush their teeth and/or allow brushing?
❏ Choke on foods or liquids?
❏ Currently put toys/objects in their mouth?
❏ Refuse to eat foods of certain textures and/or colors?
❏ Have food allergies?

Does your child…

❏ Repeat sounds, words, phrases over and over?
❏ Understand what you are saying?
❏ Retrieve/Point to common objects upon request (ball, shoe, cup)?
❏ Follow simple directions (“Shut the door” or “Get your shoes”)? ❏ Respond correctly to yes/no questions?
❏ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using…
❏ Body language
❏ Sounds
❏ Words (shoe, doggy, up) ❏ 2-4 word sentences
❏ Sentences longer that four words ❏ Other: _____

Behavioral Characteristics:

❏ Cooperative
❏ Restless
❏ Attentive
❏ Poor eye contact
❏ Willing to try new activities
❏ Destructive/Aggressive
❏ Separation difficulties
❏ Withdrawn
❏ Easily frustrated/Impulsive
❏ Inappropriate behavior
❏ Stubborn

❑ Self-abusive behavior

❑ Plays along for a reasonable length of time

❑ Easily distracted/Short attention span

School History

If your child is in school, please answer the following:

Name of the school and grade in school: _____

Teacher's name: _____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subjects?_____

_____

What do you see as your child's most difficult problem in school?

_____

Speech History

Do you feel your child has a speech problem? □Yes □No If yes, please describe:

_____

_____

Do you feel your child has a hearing problem? □Yes □No

If yes, please describe: _____

_____

Has he/she ever had a speech evaluation/screening? □Yes □No If yes, please describe: _____

_____

Has he/she ever had a hearing evaluation/screening? □Yes □No If yes, when and where: _____ What were you told: _____

_____

Has your child ever had speech therapy: □Yes □No

If yes, when and where: _____

What were they working on: _____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? □Yes □No

If yes, please describe: _____

_____

_____

I understand that it is my responsibility to inform AASLC of any changes to my child's health, such as a new diagnosis, medical procedure or hospitalization. I will inform AASLC if another provider has been added to my child's care team so that my child's care is coordinated appropriately. I will also inform AASLC if there are any changes to my child's insurance coverage, or any changes to an IEP or other relevant school-related issues.

_____

Signature of Parent/Guardian/ authorized representative NAME Date