Achievement Therapy Center, LLC
Therapy for Children
235 E. 9th Ave. Anchorage, AK 99501
(907) 334-9001
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www.TherapyForChildren.net

SPEECH / LANGUAGE INTAKE **Patient Name** _____

What age did your child demonstrate the following (estimate):

Cooing, pleasure sounds _____ Babbling (ba-da, da-da) _____ Jargon (own special language) _____

Single Words _____ Phrases (go bye-bye, more juice) _____ Short sentences _____

Does your child:

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

Does your child currently communicate using...

Body language YES NO Sounds (vowels, grunting) YES NO

Words (shoe, doggy, up) YES NO 2 to 4 word sentences YES NO

Sentences longer than four words YES NO Other _____

How often would you say you understand your child’s speech?

Less than 50% of the time _____ 50%-75% of the time _____ 75%-100% of the time _____

Has your child received or been evaluated for any other therapies? YES NO

Where, when, and for what therapy? _____

Results of evaluation? _____

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ORAL / FEEDING

Any feeding problems as an infant? YES NO Was he/she colicky? YES NO

If yes, for how long _____ When did your child transition to spoon feeding? _____

Did he/she tolerate: Stage one _____ Stage two _____ Stage three _____

Mixed textures _____ Fork mashed _____ Meltables _____

Any history of the following:

Neurological:

CNS Anomaly _____ Trauma _____ Seizures _____ Hydrocephalus _____

Microcephaly _____ Meningitis _____ Cerebral palsy _____

Respiratory:

Pneumonia _____ Bronchiolitis _____ Sinusitis _____ BPD (bronchopulmonary dysplasia) _____

Apnea _____ Laryngomalacia _____ Tracheomalacia _____ Stridor _____

Oxygen _____%, duration needed _____ Ventilator _____

Gastrointestinal:

GERD _____ Esophagitis _____ Failure to Thrive _____ Short Gut Syndrome _____

Constipation _____ Vomiting _____ Formula Changes _____

Does your child avoid any foods? YES NO

Does your child seem overly sensitive to smells? YES NO

What types of foods does your child like? _____

_____

Does your child have any feeding/swallowing problems? YES NO

If yes, please describe _____

_____

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BEHAVIOR/TEMPERAMENT

Please describe your child's personality: _____

_____

How do you handle behavior problems or tantrums at your house? _____

_____

Does your child have tantrums? YES NO How often? _____
Is your child an early riser or slow to get going? _____
Does your child like a routine? YES NO

Is he/she bothered by breaks in routine? YES NO
Can your child play alone? YES NO
Does your child play alone all of the time? YES NO
Who does your child prefer to play with? _____

Does your child demonstrate self-stimulating behaviors? YES NO
If yes, please describe: _____

Does your child sleep through the night? YES NO
Does your child wake during the night? YES NO
Does your child sleep in their own bed? YES NO
Does your child have difficulty going to sleep? YES NO
What are your child's favorite toys? _____
Where does he/she like to play? _____
Does your child have any favorite games or activities? YES NO