LUCIA REARDON
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M.A.CCC-SLP

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Client Intake Form (Parent on behalf of Child)

Full Name of Child: _____

Date of Birth: _____

Age and Grade in School: _____

School Name: _____

Parent(s)/ Guardian(s) Name(s): _____

Home Address(es): _____
Home Phone: _____
Cell Phone: _____
Other #: _____
Email Contact(s): _____

Physician's Name: _____

Health History:
Does your child have a specific diagnosis/diagnoses?

_____ At what age? _____

_____ At what age? _____

_____ At what age? _____

Any difficulties at birth or right after birth? _____

History of high fevers, convulsions? _____

Accidents or surgeries? _____

Frequent or chronic ear infections? _____

Allergies (foods, etc.) _____

Does your child regularly take medication? If so, please indicate type of medication and reason for medication:

_____

Is your child on a special diet? Please specify: _____

Developmental History:
Did your child develop speech and language milestones at the same rate and manner as typical peers?

Did or does your child struggle with processing sensory input?

If applicable, are there any problems understanding your child's communication? If yes, please explain:

Do other members of the family or teacher's have difficulty understanding your child?

Does your child struggle with finding words?

Does your child experience any frustration with making himself/herself understood, or getting his/her ideas across?

Do you have any concerns about how your child understands language skills (i.e., following directions, answering questions)? If yes, please explain:

Executive Function History:
What does your child find easy/enjoyable academically? What does your child struggle with academically?

Can your child prioritize, initiate and execute tasks associated with homework?

Is your child able to estimate how long it will take to complete a task similar to peers?

Can your child break large tasks or assignments into subtasks and timelines?

Does your child consistently leave tasks or assignments until the last minute?

Is your child able to adjust to changing circumstances or unexpected events in stride similar to same age peers?

Do small things affect your child emotionally and distract him or her from tasks at hand?

Is procrastination a problem for your child?

Social History:
How is your child doing socially in school?

Is your child invited to parties, or social events by peers?

Does he/she have friends?

Does your child show understanding of the feelings of others?

Does your child understand of the body language and facial cues of others?

Is your child aware of how he/she appears to others?

Is your child able to engage in socially appropriate and reciprocal behavior and conversation with his or her peers in a variety of settings/situations?

What are your child's social strengths?

What are your child's social weaknesses?

Describe some specific social difficulties experienced by your child.

What are your child's interests and is he/she able to disengage from this/these activity/ies if asked to or is required to engage in a less preferred activity?

Overall, how would you describe your child (e.g., happy, nervous, sense of humor, etc.)?

Family History:
Names and ages of child's siblings:

Do you have any pets at home? If so, name and type:

Is there any history of speech/language or learning difficulties in your family? If yes, please explain.

What language(s) are spoken your home?

Evaluation History:
Has your child been seen for a speech/language, learning, psychological or neurological evaluation?
If yes, please explain reason for the evaluation and briefly summarize the findings of the evaluation.

Is your child under the care of another professional (i.e., psychologist/ psychiatrist/counselor)? Please specify and give the reason why:

Has your child received communication, social-cognitive or executive function therapy in the past? If yes, please indicate the type of therapy and the approximate dates of therapy.

Has your child ever received a hearing evaluation? If yes, please indicate when the evaluation was done, who conducted the evaluation and the general results of the evaluation.

Summary:
What are your goals for your child?

Please provide any additional information or insight here that you consider important:

All of the information you have provided in this form will be kept confidential and will only be used for evaluative and therapeutic purposes. Please return the completed form to Lucia Reardon (MA, CCC-SLP) via email (luciareardon@hotmail.com)

Please note that Lucia Reardon Speech Language Pathology, LLC does not accept payment through insurance companies. Clients are provided with a monthly bill that may be submitted to their health insurance, if appropriate.

Clients must read, understand and agree to the terms and conditions in the Policies and Procedures of Lucia Reardon Speech Language Pathology, LLC (this document can be read on the website under CONTACT and clients will be provided with a printed copy as well) and agree to be responsible for the payment for speech and language therapy treatment, evaluation and consultation services rendered as outlined to commence and receive services.

This form will be printed out at the time of the first consultation. The parent/guardian/client will sign and date it and the form will be retained in the client's file.

Signature of Parent/ Guardian (18 years or older): _____
Date: _____

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