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Client Full Name: _____ DOB: ____/____/_____ Age: ____y____m

School _____ Grade _____
Is the client verbal, limited verbal, or non-verbal? Verbal
Languages spoken at home _____ Languages spoken at school _____
Interviewee's name _____ Relationship to client _____
Who referred for evaluation _____ Reason for referral _____
Diagnosis _____
Medical concerns _____
Hearing concerns _____
Vision concerns _____
Hand preference/dominance when writing _____

Pregnancy/Birth and Development
At how many weeks gestation was the client born?_____
What hospital was the client born in?_____
Where is the hospital located (city, state)?_____
Was the client born via vaginal delivery or cesarean section (C-section)? Vaginal Delivery
If c-section, why?_____
What was the client's birth weight? _____ Birth height?_____
If any, explain complications during pregnancy?_____
If any, explain complications during labor?_____
If any, explain complications during delivery?_____
If any, explain complications after delivery?_____
Did the client experience any feeding problems as a newborn? Yes
If yes, what feeding problems?_____
Were there any medical problems at birth (such as: seizures, jaundice, infections, etc.)? Yes
If yes, what medical problems? _____
Did the client pass the hearing screening for newborns at the hospital? Yes
Were there any delays with the client's physical developmental milestones (lifting head, sitting up, crawling, standing, walking, etc.)? Explain. _____
Was the client coordinated when he/she began walking? _____
Did the client fall down frequently after learning to walk?_____
At what age did the client's first words emerge (in each language)?_____
What was the client's first words in each language?_____

Medical History

Who is the client's primary care physician (PCP)?List name and city, state. _____
Has the client seen any other doctors/specialists? List names and city, state._____
What is the reason for visiting these other doctors/specialists?_____
What are the client's diagnosis? _____
Has the client had any surgeries in the past? Which one(s) and why? _____
Is the client scheduled for any surgeries in the future? Which one(s) and why? _____
Is the client now, or has the client ever been, on any medications? Which one(s) and why?_____

_____
Explain any other medical problems_____
List all allergies _____
What is the date/results of the client's most recent hearing screening? _____
Does the client experience frequent ear infections either now or in the past? Yes _____
What is the date/results of the client's most recent vision screening?_____
What is the client's overall health (poor, good, excellent)? Poor _____
Does anyone else in the immediate or extended family have a history of learning disabilities, diagnoses, etc.? Explain._____

Educational History

Did the client receive Early Intervention (EI) services? Yes _____
List all EI therapies and mandates_____

_____
Did/does the client attend daycare? Yes _____
Daycare start date _____ Daycare end date _____
Did/does the client attend preschool? Yes _____
Preschool start date _____Preschool end date_____
Did the client receive services from the Committee on Preschool Special Education (CPSE)? Yes _
List all CPSE therapies and mandates_____

_____
Aside from the current school, has the client attended other schools in the past? Which one(s) and when?_____
Is the client in a General Education **or** Special Education classroom setting?_____
How many students are in the classroom?_____
How many teachers are in the classroom?_____
What is the name **and contact information** of the client's teacher(s)?_____

_____
How is the client's overall attendance? Poor _____
Aside from COVID-19 remote learning, explain any other interruptions to education_____

_____
Explain all emotional concerns_____
Explain all behavioral concerns_____
Does the client receive therapy in school or out of school? List therapies and mandates. _____

_____
Please list all of the student's current therapies **including** mandates, therapist names, and therapist contact information _____

_____
What are your academic concerns?_____

_____
What are the client's academic strengths?_____

What are the client's academic struggles?_____

Does the client require any extra classroom or teacher support?_____

What specific reading tasks are difficult for the client? Circle all that apply:
Decoding Proofreading Comprehension Eye problems/fatigue Reading speed Reading fluency
Other: _____
What specific writing tasks are difficult for the student? Circle all that apply:
Legibility Holding utensil Hand pain/fatigue Spelling Pre-writing Organizing ideas Needs scribe
Other: _____
What would you like to see the client do that s/he cannot do now?_____

Please list additional information that you think would be useful for the upcoming evaluation(s):

Current Status

Where does the client live (city, state)?_____
Who lives with the client? (relation, gender, age) _____
What language does the client speak to family/peers/friends in?_____
Aside from COVID-19, explain any significant life changes recently or in the past? (divorce, deaths, births of siblings, immigration, family members moving in/out, high family mobility, etc.)_____

Does the client have appropriate frustration tolerance?_____
Does the client present with difficulty self-regulating when upset?_____
Does the client have any nervous habits?_____
Does the client present with separation anxiety? With who?_____
Does the client use adequate eye contact? (independently, with sounds, with name) None
What are some things that the client enjoys?_____
What are some things that the client does not enjoy?_____
Does the client watch TV? ____ How many hours per week? _____ In what languages? _____
Does the client listen to the radio? ____ How many hours per week?_____ In what languages? _____
How often does the client read per week? _____
Do you read together or does the client read independently? _____ In what languages? _____
How many hours does the client nap? _____ Hours of sleep at night? _____
Does the client toss/turn when sleeping? _____ Does the client wake up throughout the night? Yes
Explain all sleeping problems? _____
At rest, does the client breathe through the nose, mouth, or both? Both
Can you hear the client breathing? Yes Does the client snore? Yes

Feeding History

Was the client fed from the breast, bottle, tube, or other? _____
Age started _____ Age completed _____
Did the client have difficulty latching to the breast Yes bottle Yes Explain _____

Did the client drink breastmilk or formula? _____
Age started _____ Age completed _____Reason for formula_____
Did the client exhibit (circle all that apply):

☐Arching ☐crying ☐spitting up ☐gagging ☐coughing ☐vomiting ☐pulling at the nipple ☐choking - other:

_____

When _____ Why did these behaviors occur? _____

How long did these behaviors last? _____

Did the client transition easily from breast to bottle, straw, cup? _____

How long did the weaning process take? _____

When was the client introduced to cereal/solids? _____

Was the client fed purees or Baby Led Weaning? _____

How did the client tolerate solids? _____

Has the client ever had (circle all that apply):

☐Swallow study (MBS, FEES) ☐Endoscopy ☐PH Probe ☐Upper GI ☐Allergy test - Other:

_____

List the findings _____

List all special diets _____

List reason(s) for special diets _____

(Please use key below to fill out this section):

i = independently
in = inconsistently
p = with prompts
c = with cues (specify which cues)
n = not observed

_____ Sit up straight in an armless chair unassisted
_____ Drinks out of a cup with minimum spillage
_____ Drinks from a straw with minimum spillage
_____ Uses a spoon with minimum spillage
_____ Uses a fork with minimum spillage
_____ Brings food to mouth with minimum spillage
_____ Brings utensils to mouth with minimum spillage

Does the client have any food sensitivities, food allergies, or other food restrictions (e.g., cultural, diet, etc.)? Yes If yes, please explain: _____

_____

List all vitamins/supplements _____

Is the client a picky eater? (e.g., avoids certain colors, textures, flavors, temperatures, etc.) Yes

Is the client specific on the brand of food items that he/she eats? Yes If yes, what brands does the client accept? _____

Is the client specific with the way the food that he/she eats is prepared or looks? Yes

Does the client eat the same foods as the family? Yes

What does the client's daily schedule look like? Include times/events _____

_____

Who feeds the client? _____ Who eats with the client? _____

Where does the client eat? _____ What chair does the client sit in? _____

Does the client's feet reach the floor? Yes Chew with lips closed? Yes

How long do snacktimes last? _____ How long do mealtimes last? _____

List other activities going on during mealtime _____

How do you know if the client is hungry or full _____

How much weight has the client lost or gained in the last 6 months? _____ Lost

Does the client have any of the following problems (circle all that apply):

☐Dental ☐Constipation ☐Diarrhea ☐GI Infections ☐Vomiting ☐Gagging ☐Choking ☐Respiratory ☐Weight - ☐Coughing during meals or drinks - Other: _____

Explain _____

Feeder emotions before feeding _____ During feeding _____ After feeding _____

Client emotions before feeding _____ During feeding _____ After feeding _____

Client behavior before feeding _____ During feeding _____ After feeding _____

Client overall appetite currently? _____

How has appetite changed over the years? _____

For the following questions, please be as specific as possible and list specific food items, categories, color, texture, flavor, seasoning, temperature, etc.:

What food does the client enjoy? _____

_____

_____

What food does the client tolerate? _____

_____

_____

What food does the client avoid/refuse? _____

_____

_____

What food would you like to see the client eat? _____

_____

_____

Please add any additional information below:_____

_____

_____

_____

_____

End of Intake Form.

Please email responses to: legenderi.slp@gmail.com

at least 24 hours before your evaluation.

Thank you!