



# Speech-Language Intake Form Kids (0-17 Years)

## Patient Information 1/9

Date: DD/MM/YYYY Child's Name: Preferred Name:

Sex: Gender: Birthdate: DD/MM/YYYY Age: School Grade Level:

Alberta Health Care #: Street Address:

Primary Guardian: Postal Code: City: Prov:

Secondary Guardian: Email:

Primary Ph #: 2 #:

Emergency Contact: Relationship: Phone #:

\* We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address?  Yes  No

## Medical Information 2/9

Family Medical Doctor's Name: Clinic:

Date of last MD visit: Reason:

What therapies has your child previously received?  Chiropractic  Massage  Acupuncture  Physiotherapy  
 Occupational Therapy  Speech Language Pathology  Psychology

\* Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your child's health practitioner?  Yes  No

## Extended Health Benefits & Other Insurance 3/9

Do you have a private insurance plan?  No  Yes

Name of primary policy holder (Parent):

Policy #:

Which Company?:

Member ID: Group #: (ABC Only)

## How Did You Hear About Us? 4/9

- Referred by Friend/Family
- Referred by Medical Doctor
- Internet/Website
- Street Sign
- Referred by Trainer/Coach
- Walk In
- Health Care Event
- Other: .....

\*Whom may we thank for this referral? .....

## Language History

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- Primary Complaint/Purpose of Appointment:** .....
- When did you first notice these difficulties?** .....
- Has the child ever been seen by another SLP for similar challenges?**  No  Yes; **Clinic and Name of SLP:** .....
- Can we contact them?**  No  Yes
- Please note all languages spoken in the home:** .....
- Language exposure % in a typical day** (ex. 60% English, 40% French) .....
- If the child speaks more than one language, which language are they better at speaking?** .....
- Which language are they better at understanding?** .....
- Does the child use a communication device (ex. iPad, poster, etc) to communicate?**  No  Yes

## Family History

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Is there a family history of:	Mother/Father	Brother/Sister	Other
Language Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Previous Medical History

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- Number of weeks during pregnancy:** .....
- Difficulties during pregnancy** (ex. medication, loss of blood, stress, etc.) .....
- Difficulties or complications during birth** (ex. ICU) .....
- Difficulties after birth** (ex. Ear infections, eating or feeding difficulties, hospitalizations, accidents, known diagnoses, etc.) .....
- Previous or current services your child obtained with the following medical professionals:**  
Check any of the following options. \*Please provide any report from previous or current medical professionals.

### Currently Obtaining Services

- Speech-Language Pathologist
- ENT
- Audiologist
- Psychologist
- Psychiatrist
- Occupational Therapist
- Social Worker
- Ophthalmologist
- Other .....

### Previously Obtained Services

- Speech-Language Pathologist
- ENT
- Audiologist
- Psychologist
- Psychiatrist
- Occupational Therapist
- Social Worker
- Ophthalmologist
- Other .....

## Hearing History

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Has your child ever obtained a hearing assessment?  No  Yes; Please list the date and results: .....

## Language Development

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Did your child babble before the age of 1? (ex. Mamama, dadada)  No  Yes

Age (months) of first words? ..... Age (months) of first short sentences? (ex. Red truck, want milk) .....

Current Language Abilities: .....

When the child speaks, are they able to be understood by:

- Their parents  Their siblings  Strangers  Other children

Does the child have any difficulty with the following:

- Producing sounds; which sounds are affected? .....
- Understanding commands outside of the routine
- Using a variety of words
- Producing complete sentences
- Telling a story speaking fluidly
- Learning the alphabet
- Reading or writing words
- Reading or writing phrases
- Have social interactions with other children their age