Provider Name: Lubna Omar, M.S. CCC-SLP
Title: Speech-Language Pathologist
Company Email: lubna@qcpeds.com
Phone Number: 563-424-2025

CHILD INTAKE FORM

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST AT YOUR CHILD'S FIRST THERAPY SESSION.

CHILD'S INFORMATION			
FULL NAME		GENDER □ Male □ Female	DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE	
DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs.			
How does your child react to being misunderstood or unable to communicate?	□ Tries again/revises □ Becomes angry/frustrated □Other: □ Gives up □ Doesn't notice		
Why are you seeking speech-language services for your child?			
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?			
How did you learn about us?			
In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. □ None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

Continue to next page.

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	□ Biological parent(s)	□ Adoptive parent(s)	□ Legal guardian(s)
	□ Grandparent(s)	□ Sibling(s)	□ Other:

In the table to the right, list all family members who live in the same home as your child.	NAME	AGE	RELATION TO CHILD

Do you have any family pets? (List name and type)	

PARENT 1 INFORMATION

FULL NAME	GENDER □ Male □ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 □ CELL □ HOME □ WORK	EMAIL	
PHONE 2 □ CELL □ HOME □ WORK	PREFERRED METHOD OF CONTACT □ PHONE 1 □ EMAIL □ PHONE 2	
PLACE OF EMPLOYMENT	POSITION	

PARENT 2 INFORMATION

FULL NAME	GENDER □ Male □ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 □ CELL □ HOME □ WORK	EMAIL	
PHONE 2 □ CELL □ HOME □ WORK	PREFERRED METHOD OF CONTACT □ PHONE 1 □ EMAIL □ PHONE 2	
PLACE OF EMPLOYMENT	POSITION	

Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)	
Are there any other languages spoken in the home? If yes, which language(s) and how often?	

Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

CHILD'S HEALTH BACKGROUND

Describe your pregnancy, including any complications.	
Describe your labor/delivery, including any complications.	

TYPE OF BIRTH (check all that apply) □ Spontaneous (not induced) □ Induced □ Vaginal □ C-section

BIRTH PLACE (hospital/birth center)	BIRTH ATTENDANT (physician, midwife)

GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	NICU □ Yes □ No How long?

Were there any complications after birth or during the first few weeks?	□ Difficulty breathing □ Difficulty feeding □ Birth defect □ Jaundice □ Seizures □ Other:

Has your child's hearing been tested? □ Yes □ No If yes, when and where?	□ Passed □ Did not pass

Describe any serious illnesses, injuries, or medical procedures your child has experienced.	
List any environmental or food allergies.	
List any routine medications your child is currently taking or has taken long term.	
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.	

CHILD'S FEEDING DEVELOPMENT

BREASTFED from _____ months until _____ months	FORMULA FED from _____ months until _____ months	BOTTLE until _____

At what age did your child begin using the following?	□ SIPPY CUP _____ months □ STRAW _____ months □ OPEN CUP _____ months □ UTENSILS _____ months
Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc.	

FAVORITE FOODS	FOOD AVERSIONS

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT	
At what age did your child begin:	□ BABBLING (bababa) _____ months □ JARGON (bada bama) _____ months □ FIRST WORD_____ at _____ months □ TWO-WORD COMBO (more milk) _____ months □ THREE-WORD COMBO _____ months/years □ SENTENCES _____ months/years □ READING LETTERS _____ years □ WRITING LETTERS _____ years □ READING WORDS _____ years □ WRITING WORDS _____ years □ READING SENTENCES _____ years □ WRITING SENTENCES _____ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	□ Parent(s) _____% □ Sibling(s) _____% □ Peers _____% □ Teacher(s) _____% □ Extended Family _____% □ Strangers _____%
Has your child's speech-language been evaluated before? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

CHILD'S STRENGTHS AND FAVORITES	
Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE TOYS	
FAVORITE MOVIES	
FAVORITE BOOKS	