

Kidz on the Move  
Speech and Language Intake Form

**General Information**

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City/Street/Zip)

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parents: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Both parents have custody? Yes/No If no, who has primary custody? \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Name and ages of siblings: \_\_\_\_\_

Referred By: \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_

Insurance company (Name and Member ID#): \_\_\_\_\_

**Medical Information**

Has your child received any previous OT or PT services? Yes/No

If so, when and where? \_\_\_\_\_

Medical Diagnosis, if any: \_\_\_\_\_

ANY KNOWN ALLERGIES: \_\_\_\_\_

If so, does your child require an epi-pen? Yes/No

Has your child received a hearing/vision test? Yes/No Results: \_\_\_\_\_

Does your child wear glasses Yes/No

Has your child had any of the following? If yes, describe and give dates.

Childhood diseases or major illnesses: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Ear Infections: \_\_\_\_\_

Ear tubes: \_\_\_\_\_

Seizures: \_\_\_\_\_

Medications: \_\_\_\_\_

**Pregnancy History**

Any medications during pregnancy? Yes/No

List: \_\_\_\_\_

Any complications? \_\_\_\_\_

**Birth History**

Was your child:

Full Term? Yes/No Birthweight: \_\_\_\_\_

Premature? Yes/No Number of weeks: \_\_\_\_\_

C-Section delivery? Yes/No

Breastfed? Yes/No

Any difficulties with nursing, sucking or breathing? \_\_\_\_\_

Developmental Milestones: Please note approximate age your child attained the following:

Rolled: \_\_\_\_\_ Sat independently: \_\_\_\_\_ Crawled: \_\_\_\_\_

Walked: \_\_\_\_\_

Toilet trained: \_\_\_\_\_

Babbled: \_\_\_\_\_ Said first words: \_\_\_\_\_ Said 1-2 word phrases: \_\_\_\_\_

**Speech and Language History**

Is there a second language spoken at home? Yes/No If so, list language: \_\_\_\_\_

Is the foreign language understood by your child? Yes/No

Is the foreign language spoken by your child? Yes/No

Does your child use gestures instead of words? Yes/No

Does your child recognize his or her difficulty? Yes/No

Is your child understood by: parents: Yes/No Peers Yes/No Unfamiliar listeners Yes/No

When did you first discover a concern?: \_\_\_\_\_

Is your child able to understand simple directions? Yes/No

How do most people react to your child's difficulties? \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_