Widener University
Institute for Speech-Language Pathology
College of Health and Human Services

PEDIATRIC INTAKE FORM

Date Form Completed: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Gender: ☐Male ☐Female ☐Other

Person filling out this form: _____ Relationship to Child: _____

Parent/Guardian 1:

Address: _____

Preferred Phone: _____ Alternate Phone: _____

E-mail Address: _____

Parent/Guardian 2:

Address: _____

Preferred Phone: _____ Alternate Phone: _____

E-mail Address: _____

REASON FOR REFERRAL

What are your primary concerns regarding your child's communication and/or feeding?

_____
_____
_____
_____

When was the problem first noticed? _____ By whom? _____

Is the child aware of the problem? ☐Yes ☐No

If yes, how does the child react to the problem?

_____
_____

Over the last 6 months, the problem has: ☐improved ☐worsened ☐remained the same

Has the child had a prior speech/language evaluation? ☐Yes ☐No

If yes, where & when?
_____

Has the child received any previous speech/language therapy? ☐Yes ☐No

If yes, where & when? _____

Has the child ever been evaluated by any other specialist? ☐Yes ☐No

If yes, please note the type of specialist(s), date(s) and reason(s):
_____
_____
_____
_____

***If the child has received any other evaluations please submit a copy of the reports with this form.**

What are your hopes or goals for scheduling an appointment with the SLP Clinic?
_____
_____
_____
_____

BIRTH HISTORY

Is your child: ☐biological ☐adopted ☐foster

Were there medical problems during the pregnancy? ☐Yes ☐No
If yes, please describe:
_____
_____

List any medications taken during the pregnancy or the delivery:
_____
_____
_____
_____

Was the child born at full term? ☐ Yes ☐ No If no, how many weeks' gestation? _____

Were there complications: During delivery? ☐Yes ☐No
After delivery? ☐Yes ☐No
If yes, please describe: _____
_____

After delivery, were there: Feeding problems? ☐Yes ☐No
Low birth weight? ☐Yes ☐No
Problems gaining weight? ☐Yes ☐No
If yes, please describe: _____
_____

DEVELOPMENTAL HISTORY

Please list the ages that the child first met these developmental milestones:
Sitting _____ Crawling_____ Walking____
First Word _____ Sentences_____ Toilet Training_____

Did your child begin making sounds by 6 months? ☐Yes ☐No

Did the child stop talking for a period of time? ☐Yes ☐No
If yes, when?: _____

Does the child have trouble hearing? ☐Yes ☐No

Has the child ever had a hearing test? ☐Yes ☐No
If yes, where and when?:_____

Has the child had "tubes" in his/her ears? ☐Yes ☐No
If yes, are the "tubes" still in? ☐Yes ☐No

Which hand does the child use most frequently? ☐Left ☐Right

Would you describe the child as coordinated? ☐Yes ☐No

Please describe your child's communication style. For example, does your child use sounds, words, phrases, or complete sentences? Please explain below:
_____
_____
_____
_____

Does the child make sounds incorrectly? ☐Yes ☐No
If yes, please explain: _____

Is the child's voice different from other children of the same age? ☐Yes ☐No
If yes, please explain: _____

Does the child repeat or "get stuck" on words/sounds? ☐Yes ☐No
If yes, please explain: _____

Does the child:

Tell a simple story	☐Yes	☐No
Express thoughts & ideas	☐Yes	☐No
Understand what is said	☐Yes	☐No
Follow directions	☐Yes	☐No
Get along with other children	☐Yes	☐No
Prefer to play alone	☐Yes	☐No
Like to read	☐Yes	☐No
Listen to stories	☐Yes	☐No

MEDICAL HISTORY

Has your child experienced any of the following health issues (please check all that apply)?

	Adenoidectomy		Head injury
	Allergies		Heart problems
	Asthma		High fevers
	Bed wetting		Meningitis
	Chickenpox		Mumps
	Chronic colds		Nasal regurgitation
	Convulsions/seizures		Pneumonia
	Dental problems		Rheumatic fever
	Difficult to manage		Rubella
	Diphtheria		Scarlet fever
	Drooling		Snoring
	Ear infections		Tonsillitis/tonsillectomy
	Encephalitis		Vision problems
	Headaches		

Please describe any other health issues or hospitalizations (accidents injuries, operations):

_____
_____
_____
_____

Please list all current medications (prescribed and OTC):

_____
_____
_____
_____

FAMILY/SOCIAL HISTORY

Who lives at home with the child?

_____
_____
_____
_____

Does the child have any siblings? ☐Yes ☐No If yes, how many? _____

Who is the child's primary caregiver? _____

Who else spends a significant amount of time with the child?

_____
_____
_____
_____

Is there a family history of:

Speech/language concerns? ☐Yes ☐No
Family member: _____

Learning disabilities? ☐Yes ☐No
Family member: _____

Reading problems? ☐Yes ☐No
Family member: _____

What games/toys does the child enjoy? _____

What television programs does the child enjoy? _____

EDUCATION HISTORY

Does the child attend school? ☐Yes ☐No Current Grade Level:_____

If yes, what school does the child attend?

_____
_____

When did your child first enroll in this school?

_____
_____

How would you describe your child as a student? Please explain:

_____
_____
_____
_____

Has the teacher expressed concerns regarding the child's communication or academic progress? Please provide details in the space below:

_____
_____
_____
_____

Does your child currently have an IFSP/IEP or receive services/accommodations? Please explain in the space below:

_____
_____
_____
_____

***If the child has an IFSP or IEP, please submit a copy with this form.**

LANGUAGE BACKGROUND AND USE

What language is best spoken & understood by the child?: _____

What other languages are spoken & understood by the child?: _____

At what age was the child exposed to each language?:_____

Has the exposure to each language been consistent over time? Please explain below:

_____
_____
_____
_____

What language is best spoken & understood by the family?:_____

What other languages are spoken & understood by the family?: _____

Is there any other information you would like to share about language exposure and use in the home or in the community?

_____
_____
_____
_____