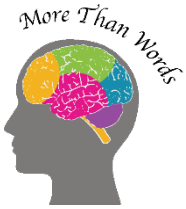

More Than Words Speech Therapy, LLC

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Intake Questionnaire

Please fill out each section as thoroughly as possible. This intake will be used during your evaluation to determine testing needs.

Basic Information:

Name: _____

Date of Birth: _____

Age: _____

Sex: _____ Ethnicity: _____

Current Employment/School Level: _____

Primary Contact Information-

Name: _____

Address: _____

Relationship: _____

Phone: _____

Email: _____

Preferred Method of Contact: _____

Secondary Contact Information-

Name: _____

Address: _____

Relationship: _____

Phone: _____

Email: _____

Preferred Method of Contact: _____

Medical History Information:

1. Was your child born prematurely, or were there any complications at birth?
   _____
   _____

2. Did your child reach developmental milestones as expected? (Ex. crawling, walking, first words, phrases, etc.)
   _____
   _____

3. Was your baby breast-fed or bottle-fed? Were there complications with either?
   _____
   _____

4. What is your child's typical diet, and are you concerned with his/her nutrition?
   _____
   _____

5. When did your child speak his/her first words? When did your child first start using phrases?
   _____
   _____

6. Significant medical conditions: _____

7. Medications taken: _____

8. Primary Care Doctor: _____

   a. Address: _____
   b. Practice Name: _____
   c. Phone number: _____
   d. Date of last visit: _____

9. When was hearing last assessed, and what were the results?_____
   _____

10. When was vision last assessed, and what were the results?_____
    _____

11. Does your child have any sensory issues? If yes, please explain.
    _____
    _____

12. Were you ever concerned with your child's development? If yes, please explain.
    _____
    _____

13. Was your child assessed by any other professionals due to these concerns? (speech therapy, occupational therapy, physical therapy, psychologists, school, etc.)
    _____
    _____

14. Did your child ever attend therapy or counseling addressing these issues? When? Where?
    _____
    _____

Family Information:

1. Your child lives with _____
2. Is your child adopted? _____
3. Are parents divorced? _____ Is there a custody agreement? _____
4. What are the languages spoken in your home? _____
5. Siblings:

Names:	Ages:

6. Please list any significant family medical history information: name of the condition, including what side the medical condition is on (father/mother):

Name of Condition:	Family Member:	Side of Family:	Details:

School Information:

1. School attended: _____ Current grade: _____
2. Has your child repeated a grade? _____If yes, please explain.
   _____
   _____
3. Has your child ever been suspended? If yes, please explain.
   _____
   _____
4. Current placement in school:

	Regular Classroom
	Homeschool
	Special Education Classroom

	Resource Room
	Alternative School
	Other

5. Have there been any changes in your child's school setting? If yes, please explain.
   _____
   _____

6. Does your child receive tutoring or any therapy at school? If yes, how often and what types?
   _____
   _____

7. On average, what grades does your child make?
   _____

8. What subjects are the easiest?
   _____

9. What subjects are the most difficult?
   _____

10. Does your child have an IEP or 504 in place? If so, please provide details on services included.
    _____
    _____

11. What are your child's strengths?
    _____
    _____

12. What types of activities does your child enjoy doing when not in school?
    _____
    _____

13. What are your hopes for this evaluation, and what are 1-3 goals you would like your child to meet in the coming year?
    _____
    _____