Advanced Speech & Language Associates, LLC

Confidential Patient Intake Form

Communication History

Patient Name: Today's Date:
DOB:

Describe your concerns regarding this child's communication skills: ____________________
When did you first become concerned? ____________________
How has the condition/problem changed since your initial concern? ____________________
What has been done about this concern? ____________________
What do you think caused this condition/problem? ____________________

Question		
Is this child non-verbal?	Yes	No
Does this child use sign language, pictures, gestures, and/or communication device? Which? ____________	Yes	No
Is this child difficult to understand?	Yes	No
Is this child easily excited?	Yes	No
Does this child display behaviors of overactivity?	Yes	No
Does this child become distracted easily?	Yes	No
Does this child get stuck on, hesitate, or repeat sounds (stutter?)	Yes	No
Does this child speak in complete sentences?	Yes	No
Did this child acquire speech/language and then appear to slow down or stop talking?	Yes	No
Does this child's communication appear delayed when compared to peers?	Yes	No
Does this child speak or understand another language besides English?	Yes	No
Does this child have a hoarse sounding voice?	Yes	No
Does this child yell more than normal?	Yes	No
Does this child echo/repeat language he/she hears, but not use it functionally?	Yes	No
Does this child have a difficult time following directions?	Yes	No
Does this child have a difficult time explaining information (ex, how he got hurt?)	Yes	No
Does this child use repetitive actions (for example, lining up objects, spinning toys, flapping hands)	Yes	No
Does this child dislike/shy away from interactions with family/unfamiliar people?	Yes	No
Does this child have a difficult time adjusting to new situations?	Yes	No
Does this child have a difficult paying attention to gestures/facial expressions?	Yes	No
Does this child have poor eye contact?	Yes	No
Does this child have a difficult time controlling his/her own behaviors?	Yes	No
Does this child play with toys appropriately?	Yes	No
Does this child have a family history of seizure disorders?	Yes	No
Does this child use a "staring-off" behavior?	Yes	No
Does this child have a difficult time sleeping (for example, sleeplessness, nightmares, wake up crying)?	Yes	No
Does this child cause injuries to him/herself (for example, head banging)?	Yes	No

Please explain other communication development that we may find helpful when treating your child: