

Advanced Speech & Language Associates, LLC
Confidential Patient Intake Form

Patient Name: _____

Today's Date: _____

DOB: _____

Describe your concerns regarding this child's strength and physical abilities: _____

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? _____

Has this child attended or currently attending any other therapies? Which? _____ Yes No

Does this child hold up his/her own head? Yes No

Was this child delayed in sitting? Yes No

Was this child delayed in standing? Yes No

Was this child delayed in walking? Yes No

Is this child toilet trained? At what age was he/she trained? _____ Yes No

Is this child somewhat awkward or uncoordinated? Yes No

Does this child fall or loose balance easily? Yes No

Does this child have any known physical disabilities? Yes No

Does this child walk without support? Yes No

Does this child appear to be overly sensitive to touching certain textures? Yes No

Does this child appear to be overly sensitive to loud noises or crowded locations? Yes No

Explain: _____

Does this child have any difficulties with fine motor skills (e.g., writing, coloring, feeding)? Yes No

Does this child exhibit any oral habits (e.g., finger sucking, nail biting, mouthing objects)? Yes No

Does this child experience any problems associated with feeding? Yes No

Does this child have any difficulties with sleeping? Yes No

Does this child demonstrate difficulty with attention? Yes No

Does this child follow motor planning directions (e.g., "clap your hands")? Yes No

Does this child climb up a slide or stairs without difficulty? Yes No

Does this child throw and catch balls? Yes No

Is this child difficult to manage (disobedient behaviors)? Yes No

Does this child have a difficult time with grooming or hygiene needs? Yes No

Does this child have difficulty with hand eye coordination? Yes No

Does this child have vision problems (seeing, squinting, straining)? Yes No

Does this child kick a ball without falling? Yes No

Does this child respond when music is played (dances, sings, taps foot)? Yes No

Does this child respond when his/her name is called? Yes No

Does this child follow simple directions about his/her daily routine ("get your shoes")? Yes No

Please explain other fine or gross motor development that we may find helpful when treating your child:

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