Communication Sciences and Disorders
Speech-Language and Hearing Clinics
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Speech-Language Clinic: Pediatric Client Intake Form

Client Information

Legal first name: Legal last name:

Preferred or lived name: Pronouns:

Date of Birth: Preferred language(s):

Mailing Address:

City: State: Zip:

Primary Care Provider/Doctor:

Parent/Guardian 1

Name: Date of Birth:

Relation to Child: Preferred language(s):

Phone: Mobile Carrier:

Email address:

Parent/Guardian 2

Name: Date of Birth:

Relation to Child: Preferred language(s):

Phone: Mobile Carrier:

Email address:

Emergency Contact:

Emergency Contact Name:
Emergency Contact Relationship:
Emergency Contact Phone:
Emergency Contact Email:

Please describe any parent or guardian restrictions, such as parenting plan or custody agreement:

Speech Clinic: Pediatric Client Case History

1. What do you hope to gain from an assessment at the WWU Speech-Language Clinic?

2. What are your child's strengths?

3. What do you see as most difficult for your child?

4. What are your areas of concern?

- ☐ Speech
- ☐ Spoken language
- ☐ Written language (reading/writing)
- ☐ Social/pragmatic communication
- ☐ Cognitive communication
- ☐ Voice
- ☐ Fluency
- ☐ Swallow/feeding
- ☐ Hearing
- ☐ Other:

5. Please list any communication or developmental diagnoses your child has, including any being considered:

6. How do these concerns/diagnoses impact your child and/or family?

7. Does your child ask for help with these challenges? If so, please provide examples:

8. Which of the following best describes your child's communication?

- ☐ My child is easy to understand, with occasional breakdowns or mistakes
- ☐ My child is easy for familiar listeners to understand but difficult for unfamiliar listeners to understand. There are frequent breakdowns or mistakes.
- ☐ My child is difficult for familiar listeners to understand. There are many breakdowns or mistakes.
- ☐ My child says few words or sounds and/or they are extremely difficult to understand.
- ☐ Other:

9. Does your child use any assistive technology or alternative means of communication (e.g. AAC device)? ◯yes ◯no

If so, please list or describe:

10. Are there specific sounds or words your child struggles to say? ◯yes ◯no

If yes, please provide some examples:

11. My child...

- ☐ is easily frustrated when other people don't understand them
- ☐ doesn't seem aware of their communication difficulties
- ☐ is teased/bullied about their communication
- ☐ tries to say sounds or words more clearly when asked
- ☐ doesn't like being asked to say sounds/words again or to repeat themselves

12. What strategies or tools help your child?

13. Is there a family history of speech, language, voice, or communication problems?

If yes, please list family members and concerns. Include any diagnoses, if known.

Prenatal, Birth, and Developmental History

14. What best describes your child's prenatal development and birth?

- ○ My child experienced typical prenatal development and birth. There were no complications or concerns.
- ○ My child's prenatal development and birth history is unknown due to adoption.
- ○ My child experienced atypical prenatal development and/or birth. There were complications or concerns.
- ○ Other:

If atypical, please describe:

15. Please select any of the following your child experienced after birth:

- ☐ Unknown
- ☐ Difficulty breathing
- ☐ Difficulty sucking
- ☐ Difficulty feeding
- ☐ Seizures
- ☐ Birth defects
- ☐ Jaundice
- ☐ Infections
- ☐ Extended hospital stay
- ☐ None of the above
- ☐ Other:

16. When did your child first meet the following developmental milestones?

Crawl:

Walk:

Draw:

Write:

First words:

Speak in short phrases:

Speak in sentences:

17. Please describe any milestones your child was late to reach or has not yet met:

Educational History

18. Name of current school:

19. School district, if applicable:

20. Current grade/level:

21. Teacher's name:
If your child has multiple teachers, please list a teacher who knows your child well. This could be a recent former teacher.

22. Teacher's email and/or phone:

23. Does your child have a 504 plan, an Individualized Education Plan (IEP), or Individualized Family Service Plan (IFSP?) ◯yes ◯no

If yes, please select the services provided through the plan:

- ☐special education classes
- ☐resource room
- ☐speech-language therapy
- ☐occupational therapy
- ☐physical therapy
- ☐literacy/reading support
- ☐Deaf education or Aural Rehabilitation
- ☐classroom accommodations

Please also list the name and contact information for specialists who work with your child:

24. Does your child receive private therapy or educational services? ◯yes ◯no
If so, please list the name of the service provider, service, and contact information:

Health and Medical History

25. Please select any medical conditions or concerns your child has had:

- ☐ Allergies
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Chronic cough
- ☐ Cleft lip or palate
- ☐ Concussion(s)
- ☐ Covid-19
- ☐ Depression
- ☐ Difficulty breathing
- ☐ Difficulty eating
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Ear infections
- ☐ Encephalitis
- ☐ GERD/Acid Reflux
- ☐ Head injury
- ☐ Headaches
- ☐ Hearing loss
- ☐ High blood pressure
- ☐ Laryngopharyngeal reflux
- ☐ Low blood pressure
- ☐ Mastoiditis
- ☐ Measles/Mumps
- ☐ Memory or concentration concerns
- ☐ Meningitis
- ☐ Other lung/respiratory disease or problem
- ☐ Otosclerosis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleep apnea or other sleep problems
- ☐ Stroke
- ☐ Tinnitus
- ☐ Voice concerns
- ☐ Vocal nodules

26. Current medical concerns, including allergies:

27. If your child sees any medical specialists, please indicate their name and specialty:

28. Are there vision or hearing concerns? ◯yes ◯no ◯unsure

If yes, please explain

29. Please list any medications your child takes:

30. Is there anything else you would like us to know?

This could include questions or goals that you have.

Signature of parent or guardian_____ Date: _____