

SZ THERAPIES INTAKE FORM

Please be thorough when completing items. Each item answered below is designed to increase accuracy and efficiency during the evaluation and leads to better treatment recommendations and outcomes. If the question is regarding an area that does not pertain to your child, please mark it N/A so the evaluator knows to disregard. There is a page at the end for additional information/descriptions. Please return to your evaluating therapist at least 24-hours prior to your evaluation. You can also scan/email to support@sztherapies.com or fax to: 303-625-4093

Thank you for taking the time to review and complete this form. We look forward to working with you and your child to understand your concerns and make a difference.

Client Information

Child's Name:	Date of Birth:	Gender: M F
Mother's Name:	Father's Name:	
Phone:	Phone:	
Occupation:	Occupation:	
Home Address:	Home Address (if different):	
Siblings (names & ages):	Languages spoken at home:	
Pediatrician/PCP:	School Attending (grade):	
Referred By:		
Date of most recent hearing screening:		R/L Pass R/L Fail

Please identify the concerns you would have addressed as part of this evaluation process (Check all that apply):

<input type="checkbox"/> Pre-Speech Skills (babble, cooing, sound play)	<input type="checkbox"/> Pre-Language Skills (verbal /gestural responses/imitation)	<input type="checkbox"/> Feeding (sucking, chewing, swallowing, drooling, etc.)
<input type="checkbox"/> Articulation (speech sound accuracy and development)	<input type="checkbox"/> Apraxia (movements required for speech)	<input type="checkbox"/> Oral Motor (structure and function of mouth/throat)
<input type="checkbox"/> Intelligibility (difficulty being understood)	<input type="checkbox"/> Speech Fluency (stuttering, cluttering, breathing coord.)	<input type="checkbox"/> Voice (quality, pitch, loudness, efficiency)
<input type="checkbox"/> Verbal Expression (vocabulary, grammar, etc.)	<input type="checkbox"/> Utterance Length (amount of words per sentence)	<input type="checkbox"/> Pragmatics (abstract and social use of language)
<input type="checkbox"/> Receptive Language (understanding of what is said)	<input type="checkbox"/> Auditory Comprehension (listening, memory, retrieval)	<input type="checkbox"/> Critical Thinking (logic, reasoning, problem solving)
<input type="checkbox"/> Attention (managing of distractions, staying focused)	<input type="checkbox"/> Behavior (compulsivity, defiance, uncontrollability)	<input type="checkbox"/> Sensory Integration (tactile, aural, visual, sent sensitivity)
<input type="checkbox"/> Learning (organization, study skills, test anxiety)	<input type="checkbox"/> Dyslexia (reading skill and reading comprehension)	<input type="checkbox"/> Written Language (translating words to text)
<input type="checkbox"/> Genetic Syndromes (Down Syndrome, VCFS, Prader-Willi, Landau-Kleffner, etc.)	<input type="checkbox"/> Traumatic Brain Injury (speech and language issues related to post injury recovery)	<input type="checkbox"/> Neurological (autism, seizures, nerve issues, other cognitive impairment, etc.)
<input type="checkbox"/> Multiple Disabilities (other health/medical impairments)	<input type="checkbox"/> Other Language (Bilingual, cultural, Sign Language, cued)	<input type="checkbox"/> Assistive Technology (skill compensation devices)
<input type="checkbox"/> Other concerns not listed (or as clarification):		

CLIENT HISTORY**Birth and Medical History**

Were there any difficulties or unusual conditions during pregnancy or labor?
How was the baby delivered?
Description of condition upon delivery (include APGAR scores and birth weight)?
Please note all known allergies:
Please note all current medications (name, dosage, purpose):
Please describe any diagnosed conditions/illnesses (e.g. asthma, croup, pneumonia, seizures):
Has the child suffered from repeated ear infections (Please describe frequency/severity)?
Please describe any surgeries the child has undergone:
Other accidents requiring hospitalization:

Developmental and Educational History

Please identify approximate ages when each milestone was attained (80 to 100% successful):			
Crawl:	Sit:	Stand:	Walk:
Breast wean:	Self-feed:	Self-toilet:	Self-dress:
First words:	Verbal protest:	Combine words:	"WH" questions:
Eye contact:	1-step directions:	Greetings:	Numbers to 5:
Pretend play:	2-step directions:	Turn taking:	Intelligible:
Attends to print:	Retells stories:	Same/different:	Express feelings:
Other milestone concerns (not listed):			
What is the child's current level of education?			
What is the child's current performance level academically (or with academic readiness skills)?			
Has the child received special services either currently or in the past (please describe qualification areas, skills addressed, and outcomes)?			

CONCERNS-BASED INTERVIEW

(Not all questions will be related to your specific concerns, please complete all that apply)

(If you need additional room, there is a blank sheet at the end of this form)

Has any siblings or family members demonstrated speech, language, and/or learning difficulties (please describe issues and resolution)?

Has the child been evaluated previously for any speech, language, or developmental issues (please include dates, purposes, and outcomes – Please also bring a copy to the evaluation)?

Has the child been evaluated for any disorders related to physical, sensory, or neurological skill (please include dates, purposes, and outcomes)?

Has the child had any difficulties with hearing related to temporary or permanent medical conditions (please describe issues and resolution)?

Has the child demonstrated any frustration behaviors related to his/her concerns (please describe the behavior and management plans)?

Please describe any problems with feeding (sucking, drooling, chewing, swallowing, etc.):

Please describe any problems with social interaction (participation in activities, joint attention, adapting to changes, sharing, predicting other's behaviors/reactions, peer relationships, etc.):

Please provide some examples of the specific speech and/or language issues that you have observed, prompting this request for evaluation?

Please describe any academic/learning concerns that you have observed:

Please describe (with examples) how the child typically communicates wants/needs (e.g. short phrases, 1-2 word combinations, gestures, alternative communication systems, etc.)?

What has had the most impact - positive or negative - on the child's ability to make progress (e.g. attention, compliance behaviors, other skills, ability to compensate, etc.)? Please describe:

ADDITIONAL INFORMATION/OTHER CONCERNS
