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**Intake Form Birth to 3 years**

**Client Name & Date:**

**Pediatrician:**

**Date of Birth:**

**Parents Names:**

**Address:**

**Cell Phone & email:**

**Medical Diagnosis:**

**Speech Diagnosis:**

**Primary concerns:**

List the foods your child is allergic to:

Please describe your expectations as a result of this evaluation:

Has your child received a medical diagnosis? If so please list all.

Who referred you for this evaluation and why?

**MEDICAL HISTORY**

Hearing Loss

Sensory/Touch

Seizures

Vision

Gross-motor

Allergies

Heart

Fine-Motor

Aspiration

Feeding

Other:

Please describe in detail all that were indicated above:

Please describe your child’s health in general:

MEDICATIONS: please list all medications

Name of Med Dosage Side Effects (e.g. appetite suppressant)

1.

2.

3.

4.

HEARING:

Has your child had any ear infections? If so, please list dates and treatment.

List your child’s hearing evaluations:

Date: Where: Results:

Do you have a follow up test scheduled?

**PRE-NATAL & BIRTH HISTORY:**

Please describe any pre-natal issues:

Please describe any relevant circumstances at birth.

**BACKGROUND INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by:**

**Birth History**

Birth uneventful?

Birth eventful? Describe:

Premature? How many weeks?

Full term?

APGAR Score:

**Medical History: Please X & elaborate on all of the following that apply.**

Hospitalizations?

Surgeries?

Medications? please list:

Seizures?

# of Ear infections Treated with antibiotics?

Frequent upper respiratory infections?

GERD? age diagnosed: How treated? Have symptoms resolved?

Eats well?

Picky eater?

Nutrition a concern? current weight? height? Wgt%: Hgt%:

Bottles fed per day? Number of ounces: Name of Formula:

Sleeps well? Please provide sleep schedule:

**Hearing Assessed:** NO YES- Results?

**Developmental Milestones:**

Sat at age: Walked at age: First words at age:

What does your child typically eat? *Please* ***x*** *all that apply*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pureed | Pureed w/lumps | Applesauce | Yogurt | Crackers |
| Rice | Mashed potatoes | Hot dogs | Chips |  |
| Bread | Cooked veggies | Raw veggies | Sandwiches |  Meat |

Self feeds with: spoon / fork

Fed by adult with: spoon / fork

Favorite Foods:

Doesn't like:

What and how does your child typically drink? *Please* ***check***

Breast Bottle Open Cup Cup w/ lid or spout Straw

Drinks independently?

Favorite Drinks:

Doesn't like:

**COMMUNICATION**

Does your child understand what you say? If so, please list the words your child understands.

Does your child follow directions? If yes, please give an example:

What is the most complex direction your child follows?

Sounds and words: Does your child communicate using cry, sounds or words? Please list:

What is a typical sentence?

How else does your child communicate? Gestures, eye gaze (or aversion), facial expression, pushing food out of the mouth, etc. Please list all.

**FAMILY**

Names and ages of siblings.

Names and nicknames of family members close to your child: (i.e.: ‘nona’/grandmother):

**Therapy history:**

Past therapy:

Name Type of therapy

Name Type of therapy

**SCHEDULE**

What time does your child nap?

Does your child attend any regularly scheduled appointments or programs?

Name : Days: Times:

1.

2.

3.

*Thank you for completely filling out this form. Please bring it with you to your appointment or you can email it to* *mbourneslp@gmail.com*