Children's Program Speech Language Intake Evaluation

Name: Date of Birth:

Completed by: Relationship to child:

Reason for evaluation referral:

Parent Concerns:

Teacher/doctor/therapist concerns:

Specific areas of concern (check all that apply)

- ☐ Functional/Basic Communication (using language to request, ask for help)
- ☐ Speech articulation (e.g. does your child have trouble pronouncing certain sounds or are they hard to understand?)
- ☐ Language (e.g. listening comprehension and expressing thoughts and ideas, answering wh-questions, vocabulary, story-telling, using age appropriate grammar)
- ☐ Literacy – reading/writing/spelling
- ☐ Stuttering
- ☐ Social Communication/Pragmatics

Developmental History

Speech and language milestones

Language spoken in the home Motor

milestones

Significant birth or medical history

Pain

Does your child report or demonstrate pain? If so, how would you rank it on a scale of 1 (low) to 10 (high).

Nutrition

Do you have any nutrition related concerns?

How would you describe your child's eating habits? (typical, picky, or restricted)

Hearing

Do you have any concerns about your child's hearing?

Date of most recent hearing screen and results

☐ Passed

☐ Referred for screening

Family History

Is there a family history of:

☐ speech and language problems

☐ learning problems,

Other developmental problems (please describe)

Is there anything else you would like your clinician to know about your family or your child?

Patient Name: DOB: