S.E.E.DS. of the Willistons Inc.

129A Hillside Avenue ● Williston Park, NY 11596 ● (516) 742-5243

By completing all requested information, we will be able to service your needs better.

All information provided will kept in strict confidence

For Office Use Only:

Evaluation Date and Time_____ Therapist_____

Client Case History Intake Form

Identifying Information

Client's Full Name: _____ Today's Date _____

Date of Birth:_____Chronological Age (years and months)_____

Address: _____

State/Zip Code: _____ Home Phone_____

PARENT/GUARDIAN E-MAIL ADDRESS:

_____@_____

Do you wish for us to correspond with you via email? ____YES ____NO

Referred by:_____ Affiliation_____

Reason for referral: please describe the concerns you have regarding your child's speech/language/social skills?_____

_____

_____

When was this problem first noticed and by whom? _____

_____

Family Information

Mother's Name:_____ Languages Spoken: _____

Address (if different from Client):_____

Occupation: _____Education Level: _____

Business Phone: _____Cell Phone: _____

Home Phone (if different from client)_____

Email Address (*If different from the one provided on page one*)_____

Father's Name: _____Languages Spoken:_____

Address (if different from client)_____

Occupation:_____ Education Level:_____

Business Phone: _____Cell Phone: _____

Home Phone: (if different from client)_____

Email Address: (*If different from the one provided on page one)*_____

Names and ages of siblings:

Name	Age	Sex	Speech/language Problems?	Remarks

Is there any other familial history of speech/language or learning problems?

_____

_____

Prenatal and Birth History

Mother's general health during pregnancy (describe any illnesses, accidents, medications, etc.)

_____

Please check any factors or conditions that may have applied to your pregnancy:

___Drug Use ___Alcohol Use ___Smoking
___Rx Medication ___High Blood Pressure ___Bed rest
___Gestational Diabetes ___Diabetes ___Insulin
___High Blood Pressure

Length of Pregnancy: _____Length of Labor: _____
Type of Delivery:_____ Birth Weight:_____

Were there any unusual conditions/complications that may have affected the pregnancy before during or after birth?_____if yes, please explain_____
_____
_____

Medical History

Physician _____Phone #: _____
Address:_____Discipline:_____

Do you want your Doctor to receive a copy of the evaluation? ____YES ____NO

Has your child been diagnosed with any specific diagnosis?_____If so, please describe his/her diagnosis:_____
_____

Has your child had or does he/she currently experience any of the following? .

Condition		Age	Treatment	Condition		Age	Treatment
Allergies	Y N			Heart Problems	Y N		
Asthma	Y N			Immune Deficiency Syndrome	Y N		
Chicken Pox	Y N			Meningitis	Y N		
Craniofacial Problems	Y N			Muscle Disorder	Y N		
Convulsions/ Seizures	Y N			Nerve Disorder	Y N		
Dental Problems	Y N			Pneumonia	Y N		
Ear Infections	Y N			Respiratory Infections	Y N		
Encephalitis	Y N			Tonsillitis	Y N		
Headaches	Y N			Vision Problems	Y N		
Head Injuries	Y N			Other:	_____		

Does your child take any medication? _____ if yes, please list name, strength, frequency and for what condition._____

Have there been any negative reactions to medications?_____ If yes, please explain.
_____
_____

Has your child had any surgeries?_____ If so, at what age? _____ Type of operation_____
_____

Describe any major accidents/hospitalizations/illnesses or diseases _____
_____
_____

Has your child ever been evaluated or treated by any of the following medical specialists:
Audiologist _____Psychologist_____Orthodontist____ Neurologist_____ Physcial Therapist_____
Occupational Therapist_____ Otolaryngologist(ENT)_____ Other (specify)_____

Specialist Name: _____Phone: _____
Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

Specialist Name: _____Phone: _____
Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

****Please provide copies of any reports that contain relevant information that would assist in assessing your child*****

Developmental History

To the best of your ability, please indicate when your child first demonstrated the following:

Skill	Age	Skill	Age
Crawling		Uses Simple Questions	
Standing (unassisted)		Phrases ("more cookie")	
Feed Self (with utensils)		Walking (unassisted)	
Toilet training (Day)		Sitting (unassisted)	
Babbles		Uses Single Words	
First Words		Uses sentences (I want __)	
Names Simple Objects		Dress Self	
Engages in Conversation		Toilet Training (Night)	

Is there any suspicion of a hearing loss? _____ Has your child's hearing ever been tested?_____
If so, where and when was the test done? _____
What were the results and recommendations of the test?_____
_____

Does your child have any difficulty walking, running, or participating in activities, which require small or large muscle coordination? If so, please describe _____
_____
_____

Does your child have any problems with eating? _____ If so, please explain_____
_____

Is your child sensitive to any type(s) of clothing, labels in clothing, textures, etc? _____
_____

Does your child engage in: thumb sucking _____Teeth grinding _____Drooling_____
Gagging_____ Temper tantrums _____Other: _____

Describe your child's responses to loud sounds (sirens, singing, alarms, door bell, vacuum, etc).
_____
_____

Present Communication Profile

Which of the following best describes your child's speech? (check all that apply)
_____Easy to understand
_____Difficult for parents to understand
_____Difficult for others to understand
_____Almost never understood by others
_____Different from other children of the same age

Does your child have trouble producing certain sounds?_____if "yes", which ones?_____
_____

Does your child hesitate and/or repeat sounds or words? Yes_____ No_____
Does your child "get stuck" when attempting to say a word? Yes_____ No_____

Is your child aware of his/her communication difficulties? Not Sure _____No _____Yes_____
If "yes", how does this awareness impact on the child's social/emotional status?_____
_____

Which of the following do you think your child understands? (Check all that apply)

_____His/her own name	_____names of objects	_____names of body parts
_____simple directions	_____complex directions	_____multi-step directions
_____"wh" questions	__ ___humor	_____figurative language
_____conversation	_____discussions	_____emotions of others

Does your child use gestures?_____ Describe_____
_____

Play Behaviors/ Social Skills

(Complete only what applies to your child's age)
Which of the following describes the type of play your child likes to engage in most often?

_____Putting toys in mouth _____Banging toys together _____Throwing toys
_____Shaking Toys _____Pushing/pulling toys _____Role playing
_____Uses one object for another _____Games with rules _____Make believe play
_____Appropriate use of objects _____Looking at books _____Acting out Familiar

What are your child's favorite activities?_____
_____

Who does your child prefer to play with? (Circle ones that apply)

Parents Siblings Peers Younger children Older Children Adults

How does your child interact with others? _____
_____
_____

Please check the behaviors that you feel best describe your child. (check all that apply)

_____Overly active
_____Overly quiet
_____Excessive tantrums
_____Destructive
_____Very Shy
_____Perfectionist
_____Friendly, outgoing
_____Plays well with peers
_____Prefers younger children
_____Able to maintain interactions
_____Uses eye contact
_____Defiant
_____Easily controlled/passive
_____Nervous
_____Dependent upon routines
_____Difficulty separating from parents
_____Flexible, able to work outside the routine
_____Imaginative and Creative
_____Prefers older children
_____Able to initiate interaction
_____Easily Distracted

How does your child interact with other children?_____

Educational History

Please list all educational programs your child attended. (including early intervention, and preschool)

Name of School	Town/City	Grade Level	Type (Reg./ Spec. Ed)	Dates

How is your child doing academically or pre-academically? _____
_____

Does your child have reading problems?_____Explain_____
_____

Any other academic or behavior problems?_____

Has your child been classified by and Early Intervention team? _____No ____Yes
Does your child receive services? ____No _____Yes, please identify

Type of Service	Frequency
Physical Therapy	
Occupational Therapy	
Speech Language Therapy	
ABA/Discrete Trial	
Teacher	
Other (describe)	

Has your child been classified by CPSE/CSE? _____No _____Yes
IF YES: What is your child's classification? _____
When was the last IEP developed? _____
What services does your child receive through his/her school district?

Type of Service	Frequency
Physical Therapy	
Occupational Therapy	
Speech Language Therapy	
Social Skills Intervention	
Counseling Services	
Resource Room	
Special Education Class	
Other	

Therapy History

Has your child ever had a Speech Language Evaluation? _____ If so, please where and when was this evaluation completed? (Please provide us with a copy of any evaluation completed within 12 months of this intake) _____
_____
_____

Has your child been previously enrolled in any speech/language or other related services?_____If so, for how long?_____Where?_____
Description of therapy program_____
Progress_____
_____
May we contact them if necessary? _____ If Yes, please provide contact information_____
_____

Is your child involved in any after school activities?_____Please describe_____
_____
_____

Please provide any additional information that you believe might be helpful in understanding your child.

_____
_____
_____
_____

If your child should participate in any of our programs, what would be your expectations be?

_____
_____
_____
_____

Informant for Case History

_____ _____
Name of Person Completing this form Relationship to Client

_____ _____
Signature of Above Person Date