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

Adult Client Case History
Intake Form

Client's Full Name: _____Date of Birth:_____

Street: _____Home Phone: _____

City:_____State:_____Zip Code:_____

Referred by:_____Phone: _____

Address:_____Affliation:_____

Please describe the concerns you have regarding your speech/language/social skills?
_____
_____
_____
_____

When was this problem first noticed and by whom? _____
_____

Have you been seen by any other specialists? Who and when? What were their conclusions and recommendations? Was a formal evaluation ever completed? _____
_____
_____
_____

Have you seen any other specialists (physicians, psychologists, neurophysiologist, etc.)? If so, indicate the specialist, when you were seen and the specialists' conclusions, diagnosis, and recommendations. Please supply any relevant reports, test findings, progress summaries).
_____
_____
_____
_____

Family Information

Name: _____ Languages Spoken: _____

Address:_____

_____

Occupation: _____Education Level: _____

Business Phone: _____Cell Phone: _____

Home Phone: _____

Email Address:_____

Medical History

Physician: _____Phone: _____

Address: _____

_____

Have you had any of the following conditions and/or diseases?

Condition	Circle one		Comment	Condition	Circle one		Comment
Allergies	Y	N		Heart Problems	Y	N	
Asthma	Y	N		German Measles	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	
Encephalitis	Y	N		Tonsillitis	Y	N	
Headaches	Y	N		Upper Respiratory	Y	N	
Head Injuries	Y	N		Vision Problems	Y	N	

Do you take any medication? _____No _____Yes, if so, please list name, strength, frequency and for what condition.

_____

_____

_____

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

_____
_____

Have you had any surgeries? If yes, please list what type and when.

_____
_____
_____

Describe any major accidents or hospitalizations.

_____
_____
_____

Do you use any assistive devices (wheelchair, augmentative communication device, etc.)? _____

Have you been evaluated by any medical specialist (psychologist, cardiologist, etc)? If so, please provide the following information. Please provide copies of any reports that contain relevant information that would assist in assessing your child.

Specialist Name: _____Phone: _____
Address: _____
Specialty: _____Date(s) Seen: _____

Specialist Name: _____Phone: _____
Address: _____
Specialty: _____Date(s) Seen: _____

Specialist Name: _____Phone: _____
Address: _____
Specialty: _____Date(s) Seen: _____

Specialist Name: _____Phone: _____
Address: _____
Specialty: _____Date(s) Seen: _____

Is there any suspicion of a hearing loss? _____ No _____Yes
Has your hearing ever been tested? _____ No _____Yes, if so, where and when was the test done? _____What were the results and recommendations of the test? _____
_____

Do you have any difficulty walking, running or participating in activities, which require small or large muscle coordination? If so, please describe: _____
_____
_____

Have you ever had any feeding problems (e.g. problems with sucking, swallowing, chewing, drooling, etc.)? If yes, please describe. _____
_____
_____

Have you had any unusual response to loud sounds (sirens, singing, alarms, door bell, vacuum, etc).
_____
_____

Do you engage in _____teeth grinding ____drooling _____ gagging
_____snoring _____Other: _____

Present Communication Profile

Which of the following best describes your speech? (check all that apply)
_____Easy to understand
_____Difficult for others to understand
_____Almost never understood by others

Do you have trouble producing certain sounds? ____No ____Yes
If "yes", which ones? _____

Do you hesitate and/or repeat sounds or words? _____No _____Yes
Do you "get stuck" when attempting to say a word? _____No _____Yes

What languages do you speak? _____
What languages do you understand? _____
What is your primary language? _____
What languages are spoken at home? _____
What is the primary language spoken at home? _____

Educational History

Please list all educational programs you have attended.

Dates	Name of School	Type	Comment

Have you ever had a Speech Language Evaluation? _____No _____Yes If so, please where and when was this evaluation completed? What were the results? (Please provide us with a copy of any evaluation completed within 12 months of this intake) _____

_____

_____

_____

Are you involved in any private support programs (e.g. Speech therapy, physical therapy, occupational therapy, music program, ABA home program, etc.) If so please list with a means of contact.

_____

_____

_____

May we contact them if necessary? _____Yes _____I prefer not, at this time.

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

_____

_____

_____

_____

_____

_____

_____

_____

_____
Name of Person Completing this form

_____ _____
Signature of Above Person Date