Intake Form

Part 1: Child Information

Child's Full Name: _____

Child Nickname (if applicable): _____

Date of Birth (DOB): _____ (MM/DD/YYYY)

Address: _____

Phone Number: _____

Gender: _____

Ethnicity: _____

Race: _____

Primary Language Spoken at Home: _____

Secondary Language Spoken at Home (if applicable): _____

Diagnosis:

Primary Diagnosis (e.g., ASD, global developmental delay, language disorder): _____

Diagnosis Date: _____

Diagnostic Professional Name: _____

Diagnostic Professional Role (e.g., developmental pediatrician, neuropsychologist, speech- language pathologist): _____

Secondary Diagnosis (e.g., ADHD, anxiety): _____

Diagnosis Date: _____

Diagnostic Professional Name: _____

Diagnostic Professional Role (e.g., neuropsychologist, psychiatrist): _____

Child Education:

Name of School: _____

School Address: _____

School Phone Number: _____

Intake Form

School Schedule:

☐ Half Day ☐ Full Day

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Type of School: ☐ Daycare ☐ Preschool ☐ Grade School ☐ Other ☐ None

Grade (if applicable): _____

Teacher Name: _____

Teacher Contact (e.g., phone number, email): _____

Does your child receive related services within the school setting?

Related Service Provider (e.g., SLP, OT, PT): _____

Frequency of Related Services (e.g., 60 minutes/week): _____

Does your child have an IFSP/ IEP/ 504 Plan?

Outside Related Service Provider(s):

Name of Related Service Provider: _____

Address: _____ (number, street, town, state, zip code)

Phone: _____

Email: _____

Related Service Provider Role (e.g., SLP, OT): _____

Frequency of Related Services (e.g., 60 minutes/ week): _____

Start Date of Related Services: _____

Name of Related Service Provider: _____

Address: _____ (number, street, town, state, zip code)

Phone: _____

Email: _____

Related Service Provider Role (e.g., SLP, OT): _____

Frequency of Related Services (e.g., 60 minutes/ week): _____

Start Date of Related Services: _____

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Primary Care Physician:

Provider Name: _____

Hospital Affiliation Name (if applicable): _____

Address: _____

(number, street name, town, state, zip code)

Phone Number: _____

Fax Number: _____

Medication(s):

Name: _____

Medication Start Date: _____

Prescribing Provider Name: _____

Prescribing Provider Role (e.g., psychiatrist, neurologist): _____

Dosage (e.g., 10mg): _____

Frequency (e.g., daily, twice a day): _____

Reason for Medication (e.g., anxiety, ADHD, seizure disorder): _____

Allergies:

Food Allergies:

_____

_____

_____

Medication Allergies:

_____

_____

_____

Does your child require an EpiPen? ☐ yes ☐ no

What is your child's EpiPen protocol?

_____

_____

_____

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Does your child have swallowing concerns (e.g., frequent coughing during mealtime, choking)?

_____

If so, did they receive a swallowing evaluation (e.g., Modified Barium Swallow - MBS evaluation, Fiberoptic Endoscopic Evaluation of Swallowing- FEES): _____

_____

Does your child require vision support (e.g., eye glasses)? _____

If so, what is their diagnosis (e.g., astigmatism)? _____

Does your child require physical support (e.g., AFO's)? _____

If so, do they have a condition related to these supports (e.g., low muscle tone)? _____

_____

Does your child require auditory support (e.g., hearing aids, cochlear implant)?

_____

If so, who is their Otolaryngologist (i.e., ENT) provider or Audiologist: _____

_____

Has your child ever experienced seizures or have a seizure disorder? _____

If so, what is their seizure protocol? _____

_____

_____

_____

Has your child's physician expressed concerns regarding your child's weight/ nutrient intake?

_____

Diet Information (e.g., consumes limited food items, consumes limited textures):

_____

_____

_____

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Birth History:

Was your child born prematurely? _____

If so, how many weeks early? _____

Did your child spend time in the NICU following delivery? _____

If so, how long? _____

What concerns were treated in the NICU? _____

_____

_____

_____

Family Health History (e.g., anxiety, learning disabilities, seizure disorder, ADHD, autism spectrum disorder):

_____

_____

_____

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Intake Form

Part 2: Caregiver Information

Parent Name: _____

Address: _____

Phone Number: _____

Work Phone Number (if applicable): _____

Email Address: _____

Preferred Contact Method (e.g., text, call, email): _____

Parent Name: _____

Address: _____

Phone Number: _____

Work Phone Number (if applicable): _____

Email Address: _____

Preferred Contact Method (e.g., text, call, email): _____

Sibling Name(s) and Ages:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Family Culture:

Are there religious considerations (e.g., praying before eating, not eating certain foods) that providers should be aware of? _____

_____

Are there cultural considerations (e.g., family roles with healthcare decisions) that providers should be aware of? _____

_____

Intake Form

Does your family talk about holiday figures such as Santa Claus and the Easter bunny? _____

_____

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Intake Form

Part 3: Parent Questions

What is your vision for your child?

_____

_____

_____

What are your child's strengths?

_____

_____

_____

What are your child's areas for growth?

_____

_____

_____

How does your child currently communicate (e.g., words, gestures, pictures)?

_____

_____

_____

What are your child's most preferred toys/ activities?

_____

_____

_____

Does your child demonstrate any dangerous or harmful behaviors (e.g., hitting head, hitting, running away)? If so, how often does this occur and when do they occur?

_____

_____

_____

Intake Form

Does your child know about their diagnosis?

_____

_____

_____

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