

DIAGNOSTIC INTAKE FORM – SPEECH/LANGUAGE/FLUENCY
Pediatric Form

Name: _____ Date of Birth: _____

Person Completing the Form: _____ Relationship: _____

Please describe you/your child's speaking difficulty: _____

When did the problem start? _____

Have you had a previous evaluation or received therapy for a speech or language disorder?

Is there a family history of speech disorder? No _____

Yes, please describe _____

MEDICAL HISTORY

Please list any illnesses or medical conditions and approximate age:

Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route (ex. oral, injection, etc.)

Allergies _____ To what? _____

Other _____

Any eating or swallowing difficulties? If yes, describe: _____

List any major surgeries, operations, or hospitalizations and dates they occurred:

List any major accidents and when they occurred: _____

Communication Strengths: _____

Communication Weaknesses/Therapy Goals: _____

Thank you for taking the time to complete our forms!