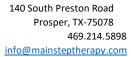


IN-TAKE FORM

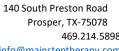
Client's Name:	DOB:	Gender
Home Address:		
Phone/cell number to best reach you:		
Parents' Names:		
Parents' Email addresses:		
Patient's Physician:		Physician's Contact #:
Physician Address:		
Name of the Insurance:	Policy Hold	der's name:
Date of Birth of the Policy Holder:	Social Security	of the policy holder:
Relationship to the patient:		
Emergency Contact:	Relationshi	ip with emergency contact:
Emergency contact number(s):		
Child's School:		Grade:
If child goes to daycare, how many days doe	s he attend?	
Does child live with both parents: Y/N		
How many siblings does the child have?	Pleas list their	genders and ages:
Does your child play well with siblings? Y/N	1	
What are your child's strengths?		
What do you like best about your child?		
What does your child enjoy?		
Does he have any strong interests?		
Does your child participate and enjoy in fam	ily activities? Y/N	
List some activities that you do as family, an	nd he/she enjoys:	



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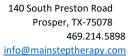
Is there any other information about your child that you feel is important for us to know and that you think
may have affected your child's language development?
Child's first language:
If bi/multilingual - child's secondary language(s):
Language child currently proficient in?
Language is predominantly spoken at home?
What date was your child's last well checkup?
Diagnosis/ Past Medical History:
Did your child pass his/her hearing screen (done at well checkups)? Y/N. If not, please list details:
Did your child pass his/her vision screen (done at well checkups)? Y/N. If not, please list details:
Has your child been evaluated or received speech therapy before?
If yes, when
Is your child receiving/has received any other intervention/support services? Y/N. If yes, please list them below
Please tell us about your primary concern about your child currently:
When did you start noticing this concern?
Has your child's pediatrician expressed any concerns regarding your child's development?
Do you have any concerns regarding child's school and education? Y/N If yes, please explain:







Does your child have a medical diagnosis? If yes, pleas	se list:
Medical History:	
Did parents have difficulty conceiving the child? Y/N	
Were there any complications during pregnancy? Y/N	Please list (if any):
Was the pregnancy full term? Y/N If not how many	/ weeks?
Were there any complications before, during or after ch	nildbirth? Y/N Please list (if any):
Was C-Section required for delivery? Y/N	
Child's birth weight:	
Was child breast-fed? Y/N For how long?	_
Did the child have any difficulty in latching? Y/N	
Developmental History:	
Please list the approximate age your child did the follow	wing:
Started babbling:	Said first words:
Said 1-2 word phrases:	Said sentences:
Ate solid foods:	
Sat unassisted: Crawled:	Walked:
Toilet trained (bladder): (bowels)	



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card number for our files.

Does your child have a history of ear infection(s)? Y/N. If so, please list age(s) infection(s) occurred:		
Has your child ever had ear tubes (Pressure Equalization)? Y/N		
Which ear and # of sets:		
Are the tubes currently in ear(s)? Y/N		
If yes, please circle the applicable: Left ear/ Right ear/ Both ears		
Does your child have a history of surgeries, head injuries, concussions, high fever, or hospitalizations? Y/N		
If so, please explain:		
Is there any other information we should be aware of before therapist starts working with your child?		
Additional comments or concerns:		
Completed by:		
Date:		

Note: Our office staff will call you to get the insurance policy holder's social security number and a credit