2025-2026 Imagine It Said New Patient Intake Form

Case History Form

Child's Name:		DOB:
Person Completing Form (relationship to child):		Today's Date:
Child's Ethnicity/Race:	Gender:	Race:
Parent/Caregiver Name(s):		
Preferred Phone #:	Additional #s:	
Address:		
Preferred email(s) for correspondence:		
Parents' Occupation(s):		
Referred By:		
Pediatrician Name:	Pediatrician Number:	

Family History

Child lives with: ☐ Birth Parents ☐ Adoptive Parents ☐ One Parent

☐ Parent & Step-parent ☐ Foster Parent(s) ☐ Other:

Siblings:

Name	Age	Name	Age

Do any close family members have a history of the following: Family member(s):

Speech-Language Difficulties ☐ YES ☐ NO _____

Learning Disabilities (eg.Dyslexia) ☐ YES ☐ NO _____

Hearing Impairment/Deafness ☐ YES ☐ NO _____

If you responded "YES" to any of the above, please explain:

_____

Is any language other than English spoken in the home? ☐ YES ☐ NO

If yes, which language? _____

Does the child speak this language? ☐ YES ☐ NO

Does the child understand this language? ☐ YES ☐ NO

Which language does the child prefer to speak at home? _____

Why is this speech evaluation being requested? _____

_____

_____

Birth History

Was the child born premature? ☐ YES ☐ NO If yes, at how many weeks? _____

Was the child healthy at birth? ☐ YES ☐ NO If no, please explain: _____

_____

Was there anything unusual about the pregnancy or delivery? ☐ YES ☐ NO

If yes, please explain: _____

_____

Medical History

Check all that apply:

☐ Tonsillitis	☐ Frequent colds	☐ Vision problems	☐ Ear (PE) tubes
☐ Adenoidectomy	☐ Seasonal allergies	☐ Wears glasses	☐ Breathing difficulties
☐ Tonsillectomy	☐ Nasal congestion	☐ Head Injuries	☐ Snoring
☐ Difficulty sleeping	☐ Chronic ear infections	☐ Other medical/genetic	☐ Hearing loss

Diagnoses: _____

Additional medical information (surgeries, hospitalizations, medications, etc.):		
Date of last hearing screening:	Location:	Results: ☐ Pass ☐ Fail
Date of last vision screening:	Location:	Results: ☐ Pass ☐ Fail

Feeding/Eating History

Check all that apply:

☐ Thumb/finger sucking ☐ Messy eater ☐ Food allergies

☐ Pacifier ☐ Limited diet ☐ Weight issues

☐ Difficulty Nursing ☐ Food texture sensitivity ☐ Picky eater

☐ Reflux/Colic ☐ Drooling observed ☐ Choking/coughing while eating

☐ Tongue Thrust ☐ Tongue or lip tie present ☐ Sensitive gag reflex

If you responded "YES" to any of the above, please explain:

_____

_____

Was your child... ☐ Breast fed ☐ Bottle fed How long? _____

Does your child primarily breathe through : ☐ Nose ☐ Mouth ☐ Both

Developmental History

Indicate the approximate age at which your child reached the following milestones:

_____Sat alone _____Walked _____Grasped crayon/pencil

_____Crawled _____Toilet trained _____Began to scribble/draw

Do you consider any physical/motor milestones to be delayed or impaired? ☐ YES ☐ NO

If yes, please explain: _____

_____

<u>Check all that apply:</u> ☐ Overly sensitive to sound ☐ Overly sensitive to touch

☐ Unusually active/fidgety ☐ Low muscle tone ☐ Clumsy ☐ Easily overwhelmed

If you checked any of the above, please explain: _____

_____

Has your child been diagnosed with a developmental disability or behavioral disorder? ☐ YES ☐ NO

If you checked any of the above, please explain:

_____

Educational/ Academic History

Does your child attend school? ☐ YES ☐ NO

Child's school/district:_____

Teacher:_____Grade:_____

Does your child have an active IFSP or IEP? ☐ YES ☐ NO

If yes, what service(s) does he/she receive?_____

Does your child have an active 504 plan? ☐ YES ☐ NO

If yes, under what eligibility/diagnosis?_____

Does your child receive any other therapies? ☐ YES ☐ NO

If yes, please list:_____

Has your child ever received a speech/language evaluation? ☐ YES ☐ NO

If yes, when and by whom?_____

Has your child received speech/language therapy previously? ☐ YES ☐ NO

If yes, when and by whom?_____

Is your child reading? ☐ YES ☐ NO

Is your child having difficulty with a particular subject? ☐ YES ☐ NO

If yes, which subject(s)?_____

Has your child ever repeated a grade? ☐ YES ☐ NO

If so, what grade and why? _____

Is your child receiving any other help at school/home (e.g., tutoring, etc.)? ☐ YES ☐ NO

If yes, please list?_____

_____

Speech & Language Development

Indicate the approximate age at which your child reached the following milestones:

_____Babbled _____Put two words together

_____Said first words _____Spoke in short sentences

	YES	NO	UNSURE
Was your child a quiet infant (limited vocalizations/babbling)?	☐	☐	☐
Did your child produce any consonant sounds in babbling by 12 months? (e.g., "mmm", "dah", etc.)	☐	☐	☐
Did your child produce consonant + vowel syllables by 18 months? (e.g., "doo", "buh", "no", etc.)	☐	☐	☐
Did/does your child produce /k/ or /g/ sounds in their babbling? (e.g., "goo", "gah", "kah", etc.)	☐	☐	☐
Did your child have 5 or more consonant sounds at 2 years old?	☐	☐	☐
Did your child have 5 or more consonant sounds at 2 years old?	☐	☐	☐
Did/does your child prefer to use /m/, /p/, or /b/ sounds over others?	☐	☐	☐
Did anything concern you about your child's speech development?	☐	☐	☐

If yes or unsure, please explain: _____

Does your child prefer to communicate with: ☐ gestures ☐ words ☐ BOTH ☐ NEITHER

Does your child:	YES	NO
Follow simple directions?	☐	☐
Follow complex or multi-step directions?	☐	☐
Ask questions?	☐	☐
Understand what you are saying?	☐	☐
Identify objects and actions easily?	☐	☐
Respond correctly to yes/no questions?	☐	☐
Is your child's speech easily understood by most people?	☐	☐

If you checked "NO" for any of the above, please explain: _____

Is your child aware of or frustrated by any speech difficulties? ☐ YES ☐ NO

If yes, please explain: _____

What are your specific concerns regarding your child's speech?_____

_____

_____

Please provide some examples of a typical sentence or utterance your child says: _____

_____

_____

_____

_____