

2024-2025 Imagine It Said New Patient Intake Form

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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:

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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 ☐ NOIf yes, please explain: _____
_____Check all that apply: ☐ Overly sensitive to sound ☐ Overly sensitive to touch☐ Unusually active/fidgety ☐ Low muscle tone ☐ Clumsy ☐ Easily overwhelmedIf you checked any of the above, please explain: _____
_____Has your child been diagnosed with a developmental disability or behavioral disorder? ☐ YES ☐ NOIf you checked any of the above, please explain: _____

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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?

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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:

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

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