

# THE L.A.F. CLINIC

*Tennessee State University*

## The Language, Articulation and Fluency Clinic SUMMER 2022 CLIENT INTAKE FORM

DATE: \_\_\_\_\_

CHILD'S FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PRIOR SPEECH SERVICES RECEIVED (When)\_\_\_\_\_ (Where)\_\_\_\_\_

PROBLEM DESCRIPTION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REFERRED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

### 2022 L.A.F. Clinic

- Clinic will run Monday-Thursday from 9:00am -3:00pm
- Dates: June 13, 2022-July 21, 2022
  - No clinic on July 4 due to holiday
- Parents-please send lunch and snack for your child each day
- Each child will receive:
  - A comprehensive Speech-Language Evaluation
  - Individualized therapy
  - A progress report at the end of clinic

**TENNESSEE STATE UNIVERSITY**  
**DEPARTMENT OF SPEECH PATHOLOGY AND AUDIOLOGY**  
330 10<sup>th</sup> Avenue North, Suite A  
Box 131  
Nashville, TN 37203-3401

**PERSONAL HISTORY-CHILD**

*Note: Please complete this form and email to: **chughe26@Tnstate.edu***

**I. GENERAL INFORMATION**

Child's Full Name \_\_\_\_\_

Current Age: \_\_\_\_\_ Birthdate \_\_\_\_\_

Gender: Male ( ☐ ) Female ( ☐ )

Address: \_\_\_\_\_  
Street City State Zip Code

Mother's Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Education Completed: \_\_\_\_\_

Residence: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Education Completed: \_\_\_\_\_

Residence: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

List all persons living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
\_\_\_\_\_

Family Physician \_\_\_\_\_

Pediatrician \_\_\_\_\_

I believe my child has difficulty with:

- ☐ Speech (articulation)
- ☐ Language
- ☐ Voice
- ☐ Fluency
- ☐ Hearing
- ☐ Other \_\_\_\_\_

Describe the problem in detail

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

What has been done to correct it? \_\_\_\_\_

How does the child seem to feel about his/her problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does any other family member have a speech or hearing problem? \_\_\_\_\_

(If yes, state nature of problem and relationship to child) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## II. EARLY HISTORY

Health of mother during pregnancy \_\_\_\_\_

Diseases, accidents, drugs, x-ray treatment of mother during pregnancy \_\_\_\_\_

\_\_\_\_\_

Exposure to any infectious diseases during pregnancy \_\_\_\_\_

Which pregnancy was this child? \_\_\_\_\_ Full term? \_\_\_\_\_

Length of labor? \_\_\_\_\_ Was delivery normal? \_\_\_\_\_

Child's weight and condition at birth\_\_\_\_\_

Describe any birth problems\_\_\_\_\_

\_\_\_\_\_

Was child's development normal for sitting, standing, walking, etc.?\_\_\_\_\_

Describe any health or feeding problems during early childhood\_\_\_\_\_

\_\_\_\_\_

**III. LANGUAGE DEVELOPMENT** (List ages carefully. This is very important.)

When did child begin to babble or coo? \_\_\_\_\_

When did child speak first words?\_\_\_\_\_Sentences\_\_\_\_\_

How does the child make his wants known?\_\_\_\_\_

\_\_\_\_\_

Was there anything different about the way the child made sounds, noises, words, etc., during the first two years?\_\_\_\_\_Explain. (Preferred to point or gesture; started talking and then stopped, etc.)\_\_\_\_\_

\_\_\_\_\_

When was the problem first noticed?\_\_\_\_\_By whom?\_\_\_\_\_

Has the child's speech changed recently?\_\_\_\_\_

What does the child do when his speech is corrected?\_\_\_\_\_

Does the child repeat your questions instead of answering them?\_\_\_\_\_

**IV. HEARING** (Complete if you think your child has a hearing problem)

What makes you think your child has a hearing problem? \_\_\_\_\_

\_\_\_\_\_

How old was the child when you realized there was a hearing problem? \_\_\_\_\_

Does he pick or pull his/her ears? \_\_\_\_\_

Does your child wear hearing aids? \_\_\_\_\_

Left Ear \_\_\_\_\_ Right Ear \_\_\_\_\_ Both Ears \_\_\_\_\_

**V. HEALTH HISTORY** (Give age and severity of following illnesses your child has had).

<u><b>Illness</b></u>	<u><b>Age</b></u>	<u><b>Describe Illness</b></u>
Measles	_____	_____
Mumps	_____	_____
Chicken Pox	_____	_____
Pneumonia	_____	_____
Allergies	_____	_____
Tonsillitis	_____	_____
Ear Infections	_____	_____

Fainting	_____	_____
Seizures	_____	_____
Diabetes	_____	_____
High Fever	_____	_____
Visual	_____	_____
Asthma	_____	_____
Frequent Colds	_____	_____
Thyroid Trouble	_____	_____
Paralysis	_____	_____
Heart Condition	_____	_____
Other	_____	_____

What operations and/or serious accidents has the child had? (Include dates)

\_\_\_\_\_  
 \_\_\_\_\_

What medication, if any, does the child receive? \_\_\_\_\_

\_\_\_\_\_

Is the child clumsy? \_\_\_\_\_ Explain \_\_\_\_\_

### **SCHOOL**

Current School \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

What is the child's attitude toward school? \_\_\_\_\_

Describe any school difficulties (reading, writing, etc.) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Has the child ever had an intelligence test? \_\_\_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

## **VI. EMOTIONAL ADJUSTMENT AND PERSONAL CHARACTERISTICS**

How would you describe the child's personality? \_\_\_\_\_

How does the child respond to people? \_\_\_\_\_

Is the child hard to manage? \_\_\_\_\_

Does the child sleep and eat well? \_\_\_\_\_

How is the child punished? \_\_\_\_\_

Has the child ever experienced a severe shock or fright? \_\_\_\_\_

If so, explain \_\_\_\_\_

**\*Notes:**

1. It is very likely that your child's session/s will be observed by students enrolled in Speech Pathology or Audiology courses.

2. It is our policy to terminate clients who are absent from therapy for 3 consecutive sessions without prior notification from the client to the Clinical Coordinator or Supervisor.