The Language, Articulation and Fluency Clinic
SUMMER 2023 CLIENT INTAKE FORM

DATE:________________________

CHILD'S FULL NAME: _____________________________________

DATE OF BIRTH: ______________

PRIOR SPEECH SERVICES RECEIVED (When)______________(Where)__________________

PROBLEM DESCRIPTION: ____

____

____

____

REFERRED BY:____DATE: ___________

2023 L.A.F. Clinic

- Clinic will run Monday-Thursday from 9:00am -3:00pm
- Dates: June 12, 20022-July 20, 2023
  - 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
  - Group therapy
  - A progress report at the end of clinic

TENNESSEE STATE UNIVERSITY
DEPARTMENT OF SPEECH PATHOLOGY AND AUDIOLOGY

330 10th 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).

Illness	Age	Describe Illness
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.

Rev. 04.06.2022