Communicate without Borders

Intake Form

Client Information

Child: _____ D.O.B.: _____

Nationality(ies) _____ Gender Male Female

Mother: _____ Telephone: _____

Father: _____ Telephone: _____

Preferred email(s): _____

_____

Please list all other children in the family:

Name	Age	Gender

Please list other people/family members living in your home:

_____

_____

_____

How long has your child been exposed to English? _____

Which language/s do you feel is/are your child's strongest? _____

Please describe the languages your child is exposed to and uses: _____

_____

_____

_____

Please briefly outline your concerns regarding the speech, language, learning, communication or development of your child: _____

_____

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When did you become concerned about your child's development? _____

Pregnancy/Birth

How many weeks was your pregnancy? _____

Were there any complications? Yes ☐ No ☐

Please describe: _____

Did your child have any feeding difficulties Yes ☐ No ☐

Please describe: _____

Health

Does your child have frequent colds, sore throat? Yes ☐ No ☐

Please describe: _____

Does your child have allergies/hay fever? Yes ☐ No ☐

Please describe: _____

Has your child experienced regular ear infections or other hearing problems? Yes ☐ No ☐

Please describe: _____

Has your child had a serious illness or accident requiring hospitalisation? Yes ☐ No ☐

Please describe: _____

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Does your child take any regular medications (e.g.asthma, diabetes, epilepsy) Yes ☐ No ☐

Please describe: _____

Has your child had tonsils or adenoids removed? Yes ☐ No ☐

If yes, when: _____

Does your child tend to breath with their mouth open? Yes ☐ No ☐

Has your child's hearing been tested? Yes ☐ No ☐

If yes, when: _____

Results: (please provide copy of report if available) _____

Has your child's vision been tested? Yes ☐ No ☐

If yes, when: _____

Results: _____

Does your child have any dental problems? Yes ☐ No ☐

Please describe: _____

Has your child previously been assessed by a specialist such as psychologist, occupational therapist, physiotherapist, speech pathologist, audiologist or other? Yes ☐ No ☐

Please describe: _____

Early Development

At what age did your child do the following?

Sitting unsupported: _____ Crawling: _____

Walking: _____ Eating solid foods: _____

Toilet trained: _____ Self-feeding: _____

First words: _____

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Two-word combinations: _____

Sentences: _____

Education

School: _____

Teacher: _____ Year: _____

At what age did your child begin attending school/daycare? _____

Please list previous schools/daycare:

School name	Dates Attended	Days per week

Please briefly describe your child's performance at school (e.g. areas of strength/weakness)

_____

_____

_____

Does your child seem to enjoy school? Yes ☐ No ☐

Does your child's school report suggest any areas are below expectations for their year group?

Reading Yes ☐ No ☐

Writing Yes ☐ No ☐

Spelling Yes ☐ No ☐

Maths Yes ☐ No ☐

Speaking or Listening Yes ☐ No ☐

Other Yes ☐ No ☐

Has your child's school discussed any concerns regarding your child's learning or development?

Yes ☐ No ☐

Please describe: _____

_____

_____

_____

What actions has the school taken in order to support your child with these challenges?

Does your child attend any specialised lessons/classes at school (e.g. speech therapy, English as a second language, learning support) Yes ☐ No ☐

Please describe:

Daily Behaviour

What are your child's favourite activities or toys? What does your child love doing?

What does your child do well?

What does your child have difficulty doing?

Does your child enjoy interacting with peers? Yes ☐ No ☐

Does your child have a best friend? Yes ☐ No ☐

Does your child seem to get frustrated about speaking, understanding or learning? Yes ☐ No ☐

Additional Comments

Is there any additional information you would like to provide regarding your child's development or history that may be relevant? Yes ☐ No ☐

Please describe: _____

Are there any specific areas or concerns you would like to discuss or address during the assessment or therapy? Yes ☐ No ☐

Please describe: _____

Relationship to child: _____

Name: _____

Date: _____

Signature: _____