Rozanne Israel, B.Sc. (Log)
Speech-Language Pathologist, Reg. CASLPO

Intake Information

Name of Child: _____ Date of birth:_____

Age: _____ Home Phone number: _____

Home address: _____

_____

Mother's name: _____Father's name: _____

Work phone: _____ □mother □ father Work phone: _____ □mother □ father

Cell Phone:_____ □ mother □father E-mail: _____ □mother □father

Cell Phone:_____□mother □father E-mail: _____ □mother □father

Siblings: _____Home language(s):_____

Paediatrician name/number: _____

BACKGROUND INFORMATION:

Reason for referral: _____

_____

_____

When did you first become concerned about this issue? _____

Has there been improvement/progress in recent months? _____

Is there a family history of speech/language/communication (or other learning/developmental) difficulties? (Please explain) _____

_____

Medical/developmental diagnosis or health concerns: _____

_____

Is your child on any medications? (please specify): _____

Is your child on any other waitlists or receiving SLP services anywhere else? Please list _____

_____

Please provide the names and numbers of any other professionals involved in your child's treatment that you feel may be relevant (E.g. Physiotherapist, Occupational Therapist, ABA, etc.) _____

_____

_____

Are you willing to provide consent for me to contact the individuals listed above? □Yes □no
(Please complete a separate consent form for each person or institution)

Has your child has his/her:
Vision checked? □Yes □no Results: _____ Date: _____

Hearing checked? □Yes □no Results: `_____ Date: _____

Does your child have a history of middle ear infections? □Yes □no

If yes, have the infections been treated with: □antibiotics □tubes □both □other

DEVELOPMENTAL MILESTONES:

To the best of your memory, please fill in the age at which your child first:

Sat _____	□not yet doing this
Crawled_____	□not yet doing this
Walked_____	□not yet doing this
Babbled (e.g. "mama", "dada", "gaga")_____	□not yet doing this
Used first words_____	□not yet doing this
Used 2 word combinations_____	□not yet doing this

FEEDING:
As an infant, was your child: □bottlefed □breastfed □both □other (E.g. G-tube)

Does your child currently:	Use a bottle	□Yes	□no
	Use a pacifier	□Yes	□no
	Suck his/her thumb	□Yes	□no

Is there a history of feeding/swallowing difficulties? □Yes □no

If yes, please explain _____

_____

Does your child have any food sensitivities/allergies or dietary restrictions? □Yes □no

If yes, please explain: _____

_____