Intake Form: Pediatric Speech/Language Services

Child's Information			
Last Name	**First Name**		
Date of Birth	**Age**	**Gender**	**Primary Language/ Language(s) Spoken**

Parent/Guardian Information Please indicate in the checkbox(es) who has the legal right to make medical decisions and access medical information for the child			
Parent/Guardian 1		**Parent/Guardian 2**	
Last Name	**First Name**	**Last Name**	**First Name**
Primary Language		**Primary Language**	
Primary Phone		**Primary Phone**	
Secondary Phone		**Secondary Phone**	
Email		**Email**	
Street Address		**Street Address**	
City, State, Zip		**City, State, Zip**	

Please put a * by your preferred method of contact (phone, email, etc.)		
I give my consent for a Voicemail/Text to be left on the telephone numbers listed above	◯ **Yes**	◯ **No**
I understand that email communication may not be secure. I give my consent to be contacted via email regarding clinic services via the email above	◯ **Yes**	◯ **No**

Chief Concerns: Please tell us about why you are coming to this clinic.
What are your concerns about your child's communication?
What are your expectations for this clinic experience?

How does your child <u>usually</u> express him/herself?			
☐	Actions (e.g., crying, pulling an adult's hand, pushing an adult's body)	☐	1-2 word sentences
☐	Sounds (e.g., babbling)	☐	2-4 word sentences
☐	Gestures (e.g., pointing)	☐	Complete sentences
☐	Other (e.g., sign language, picture exchange, communication board or device)		
Please describe:			

How often can <u>you</u> understand what your child is saying?			
◯	All the time	◯	Some of the time
◯	Most of the time	◯	Almost never
Comments:			

How often can <u>others</u> (e.g., teachers, extended family members) understand what your child is saying?			
◯	All the time	◯	Some of the time
◯	Most of the time	◯	Almost never
Comments:			

Are any of the following a concern for your child?	**Yes**	**No**
Expresses frustration when trying to communicate	◯	◯
Has difficulty pronouncing certain sounds	◯	◯
Has difficulty answering questions	◯	◯
Has difficulty following directions	◯	◯
Struggles to convey clear message when speaking, even if words are easy to understand	◯	◯
Gets stuck on or repeats words when talking	◯	◯
Has difficulty with his/her voice, vocal quality or breathing	◯	◯
Has a hard time making friends	◯	◯
Has difficulty understanding and following social rules	◯	◯

Please explain any "yes" answers about your concerns. Please give examples.

Birth/Health History

Please explain any difficulties before, during or after the birth of your child (or check none):

☐ **None**

Please explain any current medical concerns (or check none): ☐ **None**

Please list any medications your child takes regularly (or check none): ☐ **None**

Hearing	**No**	**Yes**	**Please Comment/Explain if yes**
Have you ever had concerns about your child's hearing?	◯	◯	
Does your child use any amplification or other devices to aid hearing?	◯	◯	
Does your child have frequent ear infections?	◯	◯	
Vision	**No**	**Yes**	**Please Comment/Explain if yes**
Have you ever had concerns about your child's vision?	◯	◯	
Does your child currently wear corrective lenses?	◯	◯	

Other Developmental Concerns

Please indicate if you have had in the past or currently have any concerns in the following areas of development:

Past Concern	Current Concern	Area of Development
		Motor (e.g., crawling, sitting, walking, running, clumsiness)
		Self-help (e.g., dressing, toileting)
		Feeding (e.g., drooling, choking, sensitivity to textures)
		Early play (e.g., using toys appropriately)

Please explain any concerns indicated:

Speech & Language Development

At what age (approximate) did your child begin to do the following:	Age
Babble (sound combinations such as “bababa” or “gaga”)	
Say first word	
Jabber in nonsense sentences that sound like adult language	
Begin to put words together (e.g, “Mommy play”, “want drink”)	
Use complete sentences	

Additional Parent/Family Information

☐ Mother	☐ Father	☐ Guardian	☐ Mother	☐ Father	☐ Guardian
Date of Birth:			Date of Birth:		
Occupation:			Occupation:		
Last grade completed:			Last grade completed:		
Divorced/Separated?			When?		

Is there any family history (including siblings) of speech, language and/or learning difficulties? If so, please describe:

Sibling Name(s)	Brother/Sister	Age

Is your child currently in any kind of school? (preschool, kindergarten, elementary, etc.)	No	Yes
	◯	◯

Name of School		Grade	
Teacher Name			
Teacher Email			
School Address			
School Phone		Fax	
Type of Classroom*			

* Montessori, General Education, Special Education, etc.

Does your child currently have an IEP?	**No**	**Yes**	**<u>If yes, please provide a copy.</u>**
	◯	◯	

Evaluation History

Has your child had any previous evaluations or testing?	**No**	**Yes**
	◯	◯

If yes, please list/explain, giving dates and locations of evaluation:

Was your child given a diagnosis or were any labels used to describe your child's strengths or difficulties as a result of the evaluation/testing?	**No**	**Yes**
	◯	◯

If yes, please list/explain:

Treatment History – OUTSIDE of school (e.g., speech-language, OT, reading, etc.)
Please provide any available reports from these sources

Therapy:	**Dates:**	**Location:**

Comments:

Therapy:	**Dates:**	**Location:**

Comments:

Whom may we thank for referring you to us?	
Name:	**Profession:**

Consent for Care and Clinic Policies Agreement Form

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR CARE

I hereby authorize the DePaul Speech Language Clinic to provide evaluation and treatment services for the above-named client. Additionally, if the faculty, staff, and/or other clinic personnel determine that the client is in need of emergency medical care, the clinic is hereby authorized to obtain the care required, at the expense of the undersigned.

I have read and understand the Consent for Care statement:_____(initials)

NOTICE OF INFORMATION PRACTICES & PRIVACY

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. To request a copy of your record or additional information about our privacy practices, please call XXXX.

SUPERVISION OF MINORS

Under state law, individuals under the age of 18 are considered minors. Parents/guardians shall not leave the clinic while a minor under the age of 18 is in therapy at this clinic.

Parents/guardians are solely responsible for determining how their children may safely travel to the DePaul Speech Language Clinic for their appointment (e.g. bus, drive, walk, bike, etc).

MOBILITY TRANSFERS AND RESTROOM PROCEDURES

Clinicians, faculty and staff are not allowed to assist with transfers and toileting. A caregiver or family member of the individual receiving services must be present when the client needs physical assistance with transferring from wheelchair to chair, during ambulation in the clinic, or for bathroom assistance.

ACCESSIBILITY

Both front and back entrances to our clinic are accessible. Both entries have automatic openers, as do our restrooms. Please let us know if you wish to request any additional accommodation(s) to facilitate receiving services from our clinic.

Accommodations requested:

OBSERVATION AND RECORDING

The services offered to individuals seen in the Clinic are part of the University's education program. DePaul University faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University facilities.

Basic Consent: I understand that by accepting services from the Clinic I consent to observation by DePaul faculty, staff, and students, either live, via recording, or via closed circuit television when I (or the client) receive services.

I understand that I (or the client) may be observed:_____**(initials)**

Full Consent: In addition, I give my consent to the DePaul Speech Language Clinic to make audio and/or video recordings and take photographs of me (or the client) while receiving services to be used for educational purposes, provided the name of the client or other personal identification information is not revealed. These data are only available for educational training purposes. All uses for commercial or research purposes are prohibited unless a separate permission is obtained. Segments of the digital recording with accompanying transcriptions may be presented in the context of academic symposia, university classes, and professional, family or client training activities.

I give my consent to be recorded for educational purposes:_____**(initials)**

CONSENT TO BE CONTACTED FOR RESEARCH

DePaul University Speech and Language Program and the DePaul Speech Language Clinic are committed to advancing clinical research to improve the lives of people living with communication disorders. Please initial below if you are interested in being contacted by faculty in this department about research studies for which you might be an appropriate participant. You can decline to participate even if you are contacted, you can rescind this offer at any time with no repercussions, your information will not be shared with anyone else on campus or in the community, and you will not be contacted unless you fit the criteria for a specific study.

I give my consent to be contacted about research:_____**(initials)**

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Care and Clinic Policy Agreement Form:

Name of Client: **Date of Birth:**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

If signed by someone other than client, state relationship to client: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

The DePaul University Speech Language Clinic is hereby given permission to send summaries of the speech- language evaluations, treatment notes, and/or treatment progress summaries to the individuals listed below. Additionally, I give my permission for the following agencies and/or professionals to release medical/educational information to the DePaul University Speech Language Clinic. I understand that the information will be treated in a confidential manner per this agreement.

Please enter names, addresses, and fax numbers. Check if we are to send information to, or receive information from, each person listed.

Send to: ☐ Receive from* : ☐

Name: _____ Fax: _____

Address: _____ City/State: _____ Zip Code: _____

Send to: ☐ Receive from*: ☐

Name: _____ Fax: _____

Address: _____ City/State: _____ Zip Code: _____

Send to: ☐ Receive from*: ☐

Name: _____ Fax: _____

Address: _____ City/State: _____ Zip Code: _____

Please provide records for time-period of ____ ____ _____through ____ ____ .

_____ _____

Signature of Client or Person Responsible for Care **Date**

Unless otherwise noted, consent for release of medical records/confidential information is valid for one (1) year from the date of signature.