PREMIERE
SPEECH AND HEARING
Your Preferred Communication Experts

DIAGNOSTIC INTAKE FORM – SPEECH/LANGUAGE/FLUENCY
Pediatric Form

Name: ____Date of Birth:______________________

Person Completing the Form: ____Relationship:______________

Please describe you/your child's speaking difficulty: ____

____

____

When did the problem start? ____

Have you had a previous evaluation or received therapy for a speech or language disorder?

____

Is there a family history of speech disorder? No ________

Yes, please describe ____

MEDICAL HISTORY

Please list any illnesses or medical conditions and approximate age:

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Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route (ex. oral, injection, etc.)

Allergies__________ To what?____

____

Other ____

Any eating or swallowing difficulties? If yes, describe: ____

____

____

List any major surgeries, operations, or hospitalizations and dates they occurred:

____

____

____

List any major accidents and when they occurred: ____

____

Communication Strengths: ____

____

____

Communication Weaknesses/Therapy Goals:____

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Thank you for taking the time to complete our forms!