Ande Ekstam, LLC
Speech-Language Pathologist
www.AndeEkstam.com

Client Intake Form

Please return by email or fax to *612-437-4595*

Today's date:		
Client's name:		
Birth date:	**Age: years**	**months**
Caregiver Name(s):		
Billing Address:		
Phone numbers:		
Email address:		

Please answer the following items as completely as you can:

Current Functioning

How does your child **move** in different environments (walk, scoot, wheelchair)?

How does your child **communicate** with you (facial expressions, gestures, speech)?

Describe how your child interacts **socially** (watches, engages, plays side-by-side)?

What **activities and toys** does your child enjoy?

How does your child play with toys (cause-effect, switch toys, pretend play)?

Personal Information

Please list any adults and children that live in your home and the relationship to your child:
(Please include nicknames.)

Who are friends, teachers etc. your child may enjoy talking about?

The most important thing I want you to know about this child is…

What are your main concerns or questions we can address during your child's evaluation?

Medical History

Please describe pregnancy and delivery of your child:

Has your child ever lost consciousness or sustained a significant head trauma?

Has your child's **hearing** been screened within the last year? If yes, what were the results?

Does your child experience **middle ear infections**? If yes, when was the last known infection?

Do you have concerns regarding your child's **vision**? If yes, has he/she received a vision evaluation, when, and with whom?

Hospitalizations and/or surgeries: Please list dates and reason (if applicable):

Please describe any additional medical concerns:

Current Health

Current **Diagnoses** and **ICD-9 codes** (if known):

Current **Medications**:

Allergies to medications or foods?

Describe any **sensory** seeking behaviors or sensitivities (noise, taste, sound, touch):

Are there any **nutritional or feeding** concerns?

Most recent height: ___________________ weight: _________________

Primary Care Physician:

Name:

Address:

Phone: Fax:

Does your child see any other **specialists**?

School Information

Name of School: Grade:

Address: Phone:

Name of Teacher:

Any **Special Education** services? Y N Please list name of providers if known.

Speech:

OT:

PT:

Other:

Next IEP/IFSP meeting?

Therapy Services

Has your child received prior **Speech or Occupational Therapy** services? Y N

Name of practice:

Dates Attended:

Address:

Phone: Fax:

Description of goals/progress:

Does your child receive **Physical Therapy** services anywhere?

Has your child received a Speech or Occupational Therapy **evaluation** in that past 12 months?

Y N *Please attach report(s).*

Equipment List (if applicable)

Please use attached questionnaire to list any equipment that your child uses or that you are interested in.

Thank you for taking the time to complete this questionnaire, it will be helpful in assessing your child's needs and planning appropriate therapy intervention!

Assistive Technology Equipment Questionnaire

Does your child have any of the following equipment? Please *check boxes* & *circle items* that apply. Please place a * next to any item that you are interesting in learning more about.

☐ **Augmentative Communication**:

Communication book   Step-by-Step   Big Mac   Hi-tech device

Switches   Mount   Other

☐ **Computer access**:

Switches   Switch port   Adaptive mouse   Adaptive keyboard   Software   Other

☐ **Environmental control units (ECU):**

Powerlink   Access to home electronics   Other

☐ **ADLs:**

Bath chair   Shower chair   Adaptive toilet seat/bedside commode

☐ **Hearing and listening aids**

☐ **Vision and reading:**   Low vision products   Glasses

(Near-sighted   Far-sighted   Strabismus   Other)

☐ **Mobility:**

Manuel wheelchair   Powered wheelchair   Walker   Gait trainer

☐ **Seating and positioning**:

Tumbleform   Feeder seat   Stander   Prone wedge
Sidelyer   Other

☐ **Transportation:**
Van   SUV   Sedan   Carseat   Tie-downs   Lift   Ramp

☐ **Orthotics:**
Hand splints   Foot/ankle orthotics   Trunk orthotic

☐ **Recreation and leisure aids:**

☐ **Other:**