S.E.E.DS. of the Willistons Inc.

129A Hillside Avenue ● Williston Park, NY 11596 ● (516) 742-5243

By completing all requested information, we will be able to service your needs better.

All information provided will kept in strict confidence

For Office Use Only:

Evaluation Date and Time_____ Therapist_____

Client Case History Intake Form
(Adolescents/Young Adults covered under parents Insurance)

Identifying Information

Client's Full Name: _____ Today's Date _____

Date of Birth:_____Chronological Age (years and months)_____

Address: _____

State/Zip Code: _____ Home Phone_____

PARENT/GUARDIAN E-MAIL ADDRESS:

_____@_____

Do you wish for us to correspond with you via email? ____YES ____NO

Referred by:_____ Affiliation_____

Reason for referral: please describe the concerns you have regarding your child's speech/language/social skills?_____

_____

_____

When was this problem first noticed and by whom? _____

_____

Family Information

Mother's Name:_____ Languages Spoken: _____

Address (if different from Client):_____

Occupation: _____Education Level: _____

Business Phone: _____Cell Phone: _____

Home Phone (if different from client)_____

Email Address (*If different from the one provided on page one*)_____

Father's Name: _____Languages Spoken:_____

Address (if different from client)_____

Occupation:_____ Education Level:_____

Business Phone: _____Cell Phone: _____

Home Phone: (if different from client)_____

Email Address: (*If different from the one provided on page one)*_____

Names and ages of siblings:

Name	Age	Sex	Speech/language Problems?	Remarks

Is there any other familial history of speech/language or learning problems?

_____

_____

Medical History

Physician _____Phone #: _____
Address:_____Discipline:_____

Do you want your Doctor to receive a copy of the evaluation? ____YES ____NO

Has your child been diagnosed with any specific diagnosis?_____If so, please describe his/her diagnosis:_____

Has your child had or does he/she currently experience any of the following? .

Condition		Age	Treatment	Condition		Age	Treatment
Allergies	Y N			Heart Problems	Y N		
Asthma	Y N			Immune Deficiency Syndrome	Y N		
Chicken Pox	Y N			Meningitis	Y N		
Craniofacial Problems	Y N			Muscle Disorder	Y N		
Convulsions/ Seizures	Y N			Nerve Disorder	Y N		
Dental Problems	Y N			Pneumonia	Y N		
Ear Infections	Y N			Respiratory Infections	Y N		
Encephalitis	Y N			Tonsillitis	Y N		
Headaches	Y N			Vision Problems	Y N		
Head Injuries	Y N			Other:	_____		

Does your child take any medication? _____ if yes, please list name, strength, frequency and for what condition._____

Have there been any negative reactions to medications?_____ If yes, please explain.
_____
_____

Has your child had any surgeries?_____ If so, at what age? _____ Type of operation_____
_____

Describe any major accidents/hospitalizations/illnesses or diseases _____
_____
_____

Has your child ever been evaluated or treated by any of the following medical specialists:
Audiologist _____Psychologist_____Orthodontist____ Neurologist_____ Physcial Therapist_____
Occupational Therapist_____ Otolaryngologist(ENT)_____ Other (specify)_____

Specialist Name: _____Phone: _____
Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

Specialist Name: _____Phone: _____

Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

****Please provide copies of any reports that contain relevant information that would assist in assessing your child*****

Present Communication Profile

Which of the following best describes your child's speech? (check all that apply)
_____Easy to understand
_____Difficult for parents to understand
_____Difficult for others to understand
_____Almost never understood by others
_____Different from other children of the same age

How does your child interact with other peers/adults?_____
_____

Educational History

Please list all educational programs your child attended.

Name of School	Town/City	Grade Level	Type (Reg./ Spec. Ed)	Dates

How is your child doing academically?_____
_____

Does your child have reading problems?_____Explain_____
_____

Any other academic or behavior problems?_____

Has your child been classified by CPSE/CSE? _____No _____Yes
IF YES: What is your child's classification? _____
When was the last IEP developed? _____

Does your child receive services? ____No _____Yes, please identify

Type of Service	Frequency
Physical Therapy	
Occupational Therapy	
Speech Language Therapy	
ABA/Discrete Trial	

Teacher	
Other (describe)	

Therapy History

Has your child ever had a Speech Language Evaluation? _____ If so, please where and when was this evaluation completed? (Please provide us with a copy of any evaluation completed within 12 months of this intake) _____
_____
_____

Has your child been previously enrolled in any speech/language or other related services?_____If so, for how long?_____Where?_____
Description of therapy program_____
Progress_____
_____
May we contact them if necessary? _____ If Yes, please provide contact information_____
_____

Is your child involved in any after school activities?_____Please describe_____
_____
_____

Please provide any additional information that you believe might be helpful in understanding your child.
_____
_____
_____
_____

If your child should participate in any of our programs, what would be your expectations be?
_____
_____
_____
_____

Informant for Case History

_____ _____
Name of Person Completing this form Relationship to Client

_____ _____
Signature of Above Person Date