SEA LION SPEECH THERAPY
SPEECH + LANGUAGE + LITERACY

Meg Pattee, MS CCC-SLP
sealionspeech@gmail.com
857-303-0355

NEW CLIENT INTAKE FORM

Date: ______________________________
Child's Name: _____________________

Overall Area(s) of Communication Concern

Which of these areas are you concerned with?

THERAPEUTIC DOMAIN	DESCRIPTION/EXAMPLE
☐ Speech	Producing sounds and sound patterns accurately to communicate in a way that others can understand
☐ Language	Understanding what is said, expressing wants, needs, comments, and questions, using words grammatically, or using language to communicate socially
☐ Literacy	Rhyming words, "sounding out" words, spelling, writing, fluency, or comprehension
☐ Fluency	Flow and/or rate of speech (ex: stuttering)
☐ Voice	Vocal quality, such as "breathy" or "hoarse"
☐ Resonance	Child sounds like they have a cold or are "talking out their nose" when speaking, or child has medical history of a cleft lip/palate
☐ Executive Functions	Age appropriate attention, time awareness, planning and goal setting, self-monitoring, problem solving
☐ Other	**Please explain:**

Insurance Information

Sea Lion Speech is currently in-network with most plans with Premera, Regence Blue Shield, and Aetna. A superbill for out-of-network coverage is available by request.

☐ **CHECK HERE** if you are in-network and would like Sea Lion Speech to bill your insurance on your behalf.

INSURANCE: ☐ Premera ☐ Regence ☐ Aetna ☐Other ____________________________

MEMBER ID# : ______________________________ GROUP #: ___________________________

Family Information

Person completing form: ____

Relationship to child: ____

Parent/Guardian name(s): ____

Address for care: ____

____

____

Best contact email: ______________________ Phone number: _______________________

Would you like to receive text updates about appointment reminders from Square appointments?

☐ YES ☐ NO

Sea Lion Speech provides services in your home. Where is the best place for therapist to park during session(s)?

____

____

Evaluations and therapy will need to be provided in a quiet spot where your child feels comfortable. Often, the kitchen table, an office, or the living room works well. SERVICES ARE OFFERED AS TELETHERAPY OPTION ONLY DURING COVID-19 PANDEMIC.

Child's Age: ____________ Date of Birth: ________________ Gender: _____________

Pediatrician: ____

Current School: _________________________________ Grade: ___________________

Birth History

Was your child born full term?

☐ YES ☐ NO

Was there anything unusual about the pregnancy or birth? ___________________

____

____

____

Medical History

Hearing

Did your child pass their newborn hearing screening?

☐ YES ☐ NO ☐ UNKNOWN

Did your child pass their last hearing screening?
Screenings typically happen once per year at school.

☐ YES ☐ NO ☐ UNKNOWN

Date of last hearing test with an audiologist: ________________

Results:

☐ normal ☐ mild hearing loss ☐ moderate hearing loss
☐ moderately-severe ☐ severe hearing loss ☐ profound hearing loss

Vision

Date of last eye exam: ________________

Results:

☐ normal ☐ other: ______________

Does your child have any of the following visual impairments?:

☐ nearsightedness ☐ color blindness ☐ amblyopia
☐ farsightedness ☐ cortical vision impairment ☐ other: ______________

Does your child use any of the following:

☐ glasses ☐ contact lenses ☐ eye patch

Dental

To the best of your knowledge, does your child have a:

☐ Underbite ☐ Overbite ☐ Open bite

http://www.smilestr8.net/about-orthodontics/common-bite-problems

Does your child currently use any of the following:

☐ braces ☐ retainers ☐ palatal expander
☐ other: ____________

Other dental/orthodontic health concerns: ________________________________

____

____

____

Ear Nose Throat

Does your child have a history of ear infections?

☐ YES ☐ NO

Has your child ever had ear tubes?

☐ YES ☐ NO

Does your child's voice often sound:

☐ normal ☐ "hoarse" ☐ like they have a cold

☐ "breathy" ☐ other: ______________

If yes, please explain:

____

____

____

Other

Other health concerns: ____

____

____

____

Does your child have food allergies or restrictions?: ___________________________

____

____

Communication History

Approximate age when your child:

babbled: ____________________

spoke first word: ____________________

combined two words: ____________________

Is there a family history of speech, language, or literacy disorders?
ex: articulation difficulties, stuttering, dyslexia, "late talkers"

☐ YES ☐ NO

If yes, please explain:

____

Which sounds (if any) are difficult for your child?

Early Developing Sounds

☐ m
☐ n
☐ “yuh” (**y**es)
☐ w
☐ p
☐ b
☐ d
☐ h

Middle Developing Sounds

☐ t
☐ g
☐ “ng” (si**ng**)
☐ k
☐ f
☐ v
☐ “juh” (**j**udge)
☐ “ch” (**ch**in)

Later Developing Sounds

☐ sh (**shi**p)
☐ “zhuh” (mea**s**ure)
☐ l
☐ r
☐ s
☐ z
☐ “th” (**th**is)
☐ “th” (**th**umb)

Approximately how many words does your child say?

☐ 1-10
☐ 100-200
☐ 10-50
☐ 200-500
☐ 50-100
☐ >500

If under 15 words, please list:

Does your child have difficulty following or understanding directions?

☐ YES ☐ NO

Do others have difficulty understanding your child when they speak ?

☐ YES ☐ NO

If yes, please explain:

☐ does not use words
☐ words are unintelligible
☐ talks too loud/soft
☐ talks too fast
☐ other

If yes, how often?

☐ occasionally
☐ 50% of the time
☐ over 90% of the time
☐ 75% of the time
☐ other: ______________

Does your child show an interest in books?

☐ YES ☐ NO

What languages are spoken in the home? : ____

Past and Current SLP Services

Date of last speech and language evaluation: ____

Has your child previously seen a speech therapist or reading tutor outside of school?

☐ YES ☐ NO

If yes, please explain:

____

____

____

Does your child currently receive speech therapy or extra reading help under an Individualized Education Plan (IEP)?

☐ YES ☐ NO

If yes, how often?

____

Has your child’s teacher expressed any concerns in regard to speech, language, or literacy?

☐ YES ☐ NO

If yes, please explain:

____

____

____

Additional questions that you would like to discuss with a speech pathologist?

____

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Other Comments

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