SUSANNA WEINBERGER
SPEECH AND LANGUAGE

New Client Intake Form

Identifying and Family Information

Child's Name_____ Birthdate: _____ ☐M ☐F

Father's Name_____ Mother's Name_____

Address:_____ Address:_____

_____ _____

Cell phone:_____ _____

Daytime phone:_____ Cell phone:_____

Work phone:_____ Daytime phone:_____

E-mail:_____ Work phone:_____

E-mail:_____

Who lives with your child?

_____

Siblings:

Name	Age	Sex	Speech/Hearing Problem?

What language(s) are spoken in the home?

_____

If a language other than English is spoken:
Who speaks the language(s)?_____
Does the child understand the language(s)? _____
Does the child speak the language(s)?_____
What language does the child prefer to speak at home?_____
Is there any family history of speech and language disorders/delays? If so please list the family member and area of delay/disorder:

_____

_____

Birth and Medical History

Was there anything unusual about your pregnancy or birth with this child?

_____

_____

How many weeks was the pregnancy? _____
What was the mother's age at the time of the child's birth?_____

Has your child had any of the following:

□Adenoidectomy	□Head injury	□Sinusitis
□Allergies	□High fevers	□Sleeping difficulties
□Breathing difficulties	□Measles	□Thumb/finger sucking
□Chicken pox	□Meningitis	□Tonsillectomy
□Colds	□Mumps	□Tonsillitis
□Encephalitis	□Scarlet Fever	□Vision problems
□Flu	□Sinusitis	

Other serious health conditions, injuries, illnesses, hospitalizations, or surgeries:

_____

_____

Medications/Reasons:_____

Primary Physician:_____ Phone:_____

Other Physician(s):_____ Phone:_____

Do you have concerns about hearing? □yes □no

Please give the date, location, and results of your child's last hearing test:

_____

Does your child have a history of ear infections? □yes □no

If yes, how many? _____ When was the last occurrence?_____

Tubes? □yes □no If yes, when were they placed?_____

Developmental History

Approximate age your child did the following:

Babbled_____	Rolled over_____
Said first word_____	Sat unsupported_____
Combined two words_____	Crawled_____
Spoke in short sentences_____	Walked_____
Current Vocab Size_____	Toilet trained_____

What are your child's favorite toys/activities?

_____

_____

_____

Does your child include others (e.g., you, siblings) in his/her play?

_____

_____

Does your child enjoy activities that are messy (shaving cream, finger paint, glue)?

_____

Does your child enjoy rough and tumble play?

_____

Does your child enjoy toys that make noise?

_____

Language Development

What are your areas of concern at this time?

_____

_____

_____

Describe how your child typically communicates his/her wants and needs (e.g., gestures, 2-word phrases, PECS, AAC, etc.):

_____

_____

_____

Does your child get frustrated when unable to communicate his/her wants and needs?

_____

What percentage of your child's speech is understood by **you**?_____
What percentage of your child's speech is understood by **others**?_____
Does your child have difficulty producing any speech sounds? If so, please describe:

_____

_____

How well does your child **understand** spoken language? (follow directions, point to items when named, etc.)

_____

_____

_____

Current School and Therapy

School:_____ Grade:_____
Teacher: _____ Does your child have an IEP?_____
School Phone:_____

Please indicate if your child receives any of the following services:

	Time/Frequency	Location	Provider	Phone
Occupational Therapy				
Physical Therapy				
Speech Therapy				
Behavioral Therapy				
Other:				

Please list and describe any previous or ongoing speech language therapy and treatment goals:

_____

_____

_____

Is there any other information you would like to share that is relevant to your child's speech and language development?

_____

_____

_____

_____

_____

_____

Therapy Policies and Procedures:

1. Treatment is based on a 50 minute treatment hour at a rate of $150/hour for clinic-based services, $175/hour for in-home services, and $450 for a formal assessment which includes a written report with treatment recommendations.
2. Payment is due at the end of each therapy session. Cash and check are accepted forms of payment. I do not accept insurance but can provide a superbill with diagnostic and treatment codes. You can submit the superbill to your insurance company if you intend to seek reimbursement. It is your responsibility to determine what reimbursement your insurance company will offer.
3. A parent or caregiver must be present at all time during therapy. If no one is home at the time of an appointment the therapist will wait no longer than 15 minutes for the client. "No shows" will be considered last minute cancellations and client will be charged in full.
4. If the therapist or client cancels an appointment (e.g., illness, vacation), effort will be made within reason to make up the missed appointment, however, preferred times cannot be guaranteed.
5. If your child is ill (i.e., demonstrating symptoms such as coughing, sneezing, runny nose, fever, vomiting, diarrhea, pink eye, etc.) please call to cancel your appointment or discuss with the therapist. If these symptoms are exhibited during your child's session the therapist reserves the right to end the session.
6. Cancellations must be made 24 hours prior to your appointment otherwise you will be charged in full.
7. Therapy can be discontinued at any time.
8. If you wish your therapist to attend an IEP and/or other team meeting, 2 weeks notice is requested at a fee of $125/hour.

Agreement:

I_____ , parent/guardian of _____
have read and understand the above stated policies, and agree to abide by them.

Signature_____Date_____