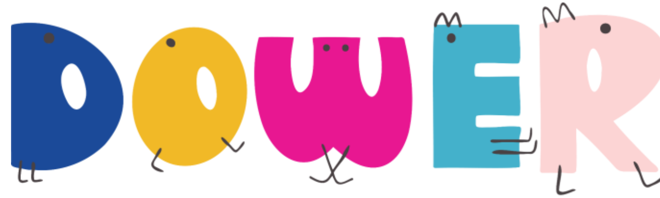

Speech Pathology + Applied Behavior Analysis

www.dowerandassociates.com | established 1993

INTAKE FORM

Speech-Language Evaluation and/or Therapy

Child's Name: ______________________ Parent Name: ______________________

Date of Birth: ______________________ Email: ______________________

Home Phone: ______________________ Cell Phone & Work Phone: ______________________

Address: ______________________ Parent Name: ______________________

Pediatrician Name/Family Doctor: ______________________ Email: ______________________

Doctor Phone/Address: ______________________ Cell Phone & Work Phone: ______________________

Referred By: ______________________

Dower and Associates, Inc.
Corporate Office Address: 9845 Business Way, Manassas, Virginia 20110
Leesburg Office Address: 20600 Red Cedar Drive Leesburg, VA 20175
Phone: (703) 618-6180 Facsimile: (703) 257- 4841
Email: information@dowerandassociates.com

Speech/Language Evaluations & Therapy * Academic & Remedial Tutoring * Educational Consultations
IEP Development & Consultations * Applied Behavior Analysis (ABA) Instruction, Consultation and Training

Reason for Referral:

___

___

___

Background and Related Information

List any siblings (with age) and other people living in the home:

___

___

List primary language(s) spoken in the home:

___

Do any family members have a history of speech, language, reading, or learning difficulty?

___

If yes, please describe and list:

___

___

Describe your child's speech, language, reading, or learning difficulty.

How does your child usually communicate? (pointing, sentences, poor grammar, difficult to understand, etc.)

___

___

When was this problem first noticed? Has the problem worsened? Can you tell the cause of the problem?

___

___

Is your child aware of the problem? Is he or she frustrated? Does he or she want to be helped?

___

___

Has your child been seen by any other specialists (physician, psychologist, therapist)? If so, when and what were your conclusions? (Please provide copies of reports.)

___

___

Birth and Developmental History

What was the condition of the mother's pregnancy, labor, and delivery? Were there any complications at birth?

____

____

Did your child reach normal developmental milestones within the average range? (Sitting, crawling, eating, sleeping, talking)

____

____

When did your child begin talking? When did your child put words together?

____

____

Has your child had difficulty learning to read?

____

____

Does your child have difficulty with functioning in the classroom, or with any subject(s)? If so, please describe:

____

How has your child's health condition been? (e.g., allergies, frequent colds, ear infections, etc.)

____

____

Has treatment of health problems been successful?

____

____

Is your child taking any medications? If yes, please indicate what medication, dosage and reason.

____

____

Please provide any additional information that might be helpful to your evaluation or remediation of your child's weaknesses:

____

____

____

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Please provide information about your child's strengths:

___

___

___

___

Please use this area to add any information that you believe is important for me to know about your child:

___

___

___

___

Person completing form: ___ Relationship to the child: ___

Signature: ___ Date: ___

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