UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
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Name: _____ Date of Birth: _____ Phone: _____

SPEECH-LANGUAGE INTAKE FORM

If the client has ever received any previous evaluations for learning, emotions, behavior, or communication concerns, please send/provide copies of these records. Please also fax any relevant medical records to: 434-924-4621

List the specific concerns you are seeking help with:

1. _____
2. _____
3. _____

What information do you hope to obtain from this evaluation?

Do you have additional concerns with any of the following?

- ☐ Have too few words in vocabulary compared to others the same age
- ☐ Difficulty combining words into well-organized sentences
- ☐ Difficulty understanding what others are saying (answering questions/following directions)
- ☐ Mispronounce or omit a sound or sounds when speaking
- ☐ Difficulty with strangers understanding your speech
- ☐ Repeat sounds, words, parts of words or phrases when talking (e.g. stuttering)
- ☐ Maintaining attention when others are speaking (eye contact, facing speaker, etc…)
- ☐ Maintaining back and forth conversation with others
- ☐ Notice a hoarse voice most of the time
- ☐ Notice voice always sounds like you have a cold
- ☐ Notice voice sounds like it is coming through the nose
- ☐ Have difficulty modulating volume (too soft or too loud)
- ☐ Other communication concerns? Please describe below:

Please describe your concerns here:

PREGNANCY AND BIRTH HISTORY:

Was the pregnancy with the client full-term? ☐ Yes ☐ No

If no, how long was the pregnancy? _____

Were there any complications during the pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

Were there problems during the delivery? ☐ Yes ☐ No

If yes, please describe: _____

DEVELOPMENTAL HISTORY:

Was the client's physical development normal? ☐ Early ☐ Normal ☐ Late

Age when child: Sat alone _____ Crawled _____ Walked _____

Was the child's speech/language/communications development normal? ☐ Early ☐ Normal ☐ Late

Age when child: Babbled _____ First word _____ Combined words together _____

HEARING STATUS

Has your child had ear infections? ☐ Yes ☐ No If so, when was the last one? _____

Has your child ever had ear tubes? ☐ Yes ☐ No If so, when? _____

EDUCATIONAL HISTORY:

Client currently attends (circle one): daycare / elementary school / middle school / high school college / university

Where: _____

Grade level: _____ Major or focus of study (if applicable): _____

Client's reading level:	☐ Below grade level	☐ On grade level	☐ Above grade level
Client's writing level:	☐ Below grade level	☐ On grade level	☐ Above grade level
Client's math level:	☐ Below grade level	☐ On grade level	☐ Above grade level

Does the client have an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)? ☐ Yes ☐ No

Is the client receiving special help or accommodations at school? ☐ Yes ☐ No If no, please explain:

Has client received any diagnoses related to learning, emotions, behaviors, communication, etc.? ☐ Yes ☐ No

If so, please explain:

Has a family member received any diagnoses or experienced significant difficulties related to learning, emotions, behavior, communication, etc.? ☐ Yes ☐ No

If so, please explain: