TIM's Camp
Marquette University
Intake Form
Summer, 2022

Person completing this form: _____ Date: _____

Relationship to child: _____

I. FAMILY INFORMATION

Name of child: _____ Nickname: _____

D.O.B: _____ Age: _____ Gender: Male Female

Mother's Name: _____ Age: _____

Address: _____

City and Zip: _____

Phone: Home: _____Work: _____ Ext. _____

Cell: _____

Email: _____

Occupation: _____ Place of Employment: _____

Check here if not living in the same home as child_____

Father's Name: _____ Age: _____

Address: _____

City and Zip: _____

Phone: Home: _____Work: _____ Ext. _____

Cell: _____

Email: _____

Occupation: _____ Place of Employment: _____

Check here if not living in the same home as child_____

On which phone do you prefer we leave messages regarding clinic enrollment?

_____ Home _____ Work _____ Mother's Cell _____Father's Cell _____ Any

_____ Do not leave messages identifying the Speech and Hearing Clinic.

Parents are: _____ Married _____ Divorced _____ Separated.

If not married, custody is with _____ Mother _____ Father _____ Joint

Brothers' and Sisters' Names	Age	Sex	School	Grades	Speech, Language or Hearing Problems
1.					
2.					

3.					
4.					

If not with parents, with whom is child living? _____

Relationship to child: _____

Address: _____ City /Zip: _____

Names and relationship to child of any others living in the home: _____

_____

_____

Indicate languages, other than English, spoken (fluently) in your home and your child's proficiency with understanding and using the other language:

Language: _____ _____Occasionally _____Frequently

_____

Language: _____ _____Occasionally _____Frequently

_____

II. MEDICAL HISTORY

Does your child have any medical or psychological diagnoses? ____No ____ Yes (If yes, please list below)

Diagnosis	Date Given	Professional and Facility Providing Diagnosis

Primary Doctor: _____ Facility/City: _____

Date last seen: _____

Please list other physicians/medical specialists treating child (e.g. neurologist, gastroenterologist, cardiologist, psychiatrist, nutritionist, etc.):

Physician	Specialty	Facility/City	Date last seen

Has your child had his hearing tested? _____ no _____ yes Date of most recent test: _____

Where/ By whom: _____

Results: _____

Does your child have any allergies? _____no _____yes

Please list: _____

_____

Does your child have any dietary restrictions? _____

_____

Please check if your child has experienced any of the following health problems.

Disorder/Illness	Yes(Y) or No (N)	If yes, Date(s)	Disorder/Illness	Yes(Y) or No (N)	If yes, Date(s)
Dehydration			Chicken pox		
Asthma			Meningitis		
Chronic colds			Severe headaches		
Pneumonia			Influenza		
Head injuries			Whooping cough		
Sinus infections			Chronic cough		
Persistent high fever			Scarlet fever		
Tonsillitis			Rheumatic fever		
Seizures			Measles		
Croup			Mumps		
Gastrointestinal problems			Encephalitis		
Cardiac problems			Kidney problems		
Injuries to mouth, throat, or face					
Fractures					
Bronchitis					

For any boxes above checked “yes” , please provide additional explanation: _____

_____

_____

_____

Describe any other serious health problems not listed above: _____

_____

_____

List any other hospitalizations or emergency room visits, with dates and reason: _____

_____

_____

_____

List any medication your child is presently taking, and for what reason: _____

_____

Does your child sleep well? (Explain any difficulties) _____

_____

Does your child eat well? (Explain any difficulties or concerns with feeding or swallowing) _____

_____

_____

IV. <u>DEVELOPMENTAL HISTORY</u>

What are your child's current interests? _____

_____

List any classes, organized activities, or sports that your child participates in: _____

_____

How does your child like to spend his/her time? _____

_____

Does your child tend to play alone or with other children? (Explain)_____

_____

Is it difficult to discipline your child? (Explain as fully as possible) _____

_____

How would you describe your child's temperament/disposition? _____

_____

Does your child have difficulty concentrating on a task? (Explain) _____

_____

Does your child show over- or under-sensitivity to sounds, light, textures, etc? (Explain) _____

_____

Do you have any particular behavior concerns about your child? (Explain):

_____

Does your child require regulation strategies utilized within the day (including, but not limited to school) ____no ___ yes

If yes, please explain the type of regulation strategy utilized and when these strategies are required

_____

V. COMMUNICATION HISTORY

Does your child speak: Frequently_____ Occasionally_____ Never _____

Does your child prefer to use speech or gestures? (Give examples if possible): _____

If your child is speaking, which of the following does he/she use most often?

Complete sentences: _____ Phrases: _____ Single words: _____ Babble/Jargon_____ Single sounds: _____

If your child is using complete sentences, please provide examples: _____

_____

Approximately what percentage of your child's speech is understood by:

Parents/Primary caregiver: _____ Siblings: _____ Peers: _____ Strangers: _____

Does your child frequently repeat sounds, syllables, words or phrases? _____ no _____ yes If yes, please explain further: _____

Does your child have difficulty producing certain sounds? _____

Does your child use sign language? _____ no _____ yes. If yes, please describe use: _____

_____

Does your child use any alternative / augmentative communication device? _____ no _____ yes

If yes, please state model, frequency and nature of use: _____

_____

How does your child communicate with other children? _____

How does he/she communicate with adults? _____

Please share any other information about your child's communication problem that you think would be helpful:

_____

_____

VI. THERAPY HISTORY

Please list all prior speech/language evaluations and therapy received (e.g., birth-to-3, private clinic, school services):

Dates of service	Therapist name	Facility/location	Evaluation/Therapy/Both Brief description

Please list other therapy / services received (e.g., physical therapy, occupational therapy, counseling, in-home behavioral therapy, hippotherapy, music therapy, etc.). Include those received in school setting.

Dates of service	Therapist name	Facility/location	Evaluation/Therapy/Both Brief description

VI. EDUCATIONAL HISTORY

Current school attending: _____ Public or Private: _____

Address: _____Grade: _____

Regular Education Teacher: _____

Special Education Teacher: _____

Speech Language Pathologist: _____

Has your child ever had an Individualized Education Plan (IEP)? _____ no _____ yes.

If yes, date of most recent IEP: _____ Date of most recent evaluation /re-evaluation: _____

Where does your child spend his time at school? Please list approximate time or percentage of time for all that are relevant:

_____General education classroom _____Special education classroom

_____ Individual pull-out _____ Self-contained (specialized / ASD) classroom

Please report out on most recent scores/levels within the following areas of district wide and state testing (these scores can be obtained from your child's special education and/or regular education teacher and can be brought to the initial intake appointment):

MAPS or STARS: (percentile/RIT):_____

PALS: _____

Guided Reading Level: _____

Please list other support services received at school (if not listed above under therapy history) : _____

_____

Please describe your child's performance in school (grades, easiest and most difficult subjects, etc.) _____

_____

How does your child feel about school and about his/her teachers? _____

_____

Describe any specific concerns you have about school: _____

_____

Do you feel your child's speech/language problem has affected him/ her at school? (Explain) _____

_____

_____

Does your child have a high interest area or motivating topic that is utilized throughout the school day? _____no____yes.

If yes, please explain _____

_____

VI. ADDITIONAL INFORMATION

Other information you feel would be helpful: _____

_____

_____

_____

Please read each statement below and initial by each:

_____I hereby consent to speech and language evaluation and treatment of _____

at the Marquette university speech and hearing clinic. (name of client)

_____I understand that in the Marquette University Speech and Hearing Clinic, Student clinicians conduct evaluation and therapy intervention under the direct supervision of licensed speech-language pathologists/faculty members.

_____I understand that evaluation and therapy sessions are observed by students as part of the training program.

_____ _____

Signature of Parent/Guardian(s) **Date**