

Miracles in Communication of Northern New Jersey, LLC

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SPEECH-LANGUAGE INTAKE FORM

<i>Today's Date:</i>		<i>How did you hear about us?</i>	
<i>Child's Name:</i>		<i>Child's Date of Birth:</i>	
<i>Mother's Name:</i>		<i>Father's Name:</i>	
<i>Address:</i>			
<i>City:</i>		<i>State:</i>	<i>Zip Code:</i>
<i>Home Phone:</i>		<i>Cell Phone:</i>	
<i>Email:</i>			

INSURANCE INFORMATION

We do not participate with any insurance companies but, will help you obtain coverage

<i>INSURANCE COMPANY:</i>		
<i>Insurance Address:</i>		
<i>City:</i>	<i>State:</i>	<i>Zip Code:</i>
<i>Insurance Phone Number:</i>		
<i>Primary Insured:</i>	<i>Primary Insured's Social Security Number:</i> - -	
<i>Insured's Employer:</i>	<i>Insured's Date of Birth:</i>	

CASE HISTORY

BIRTH WEIGHT:		
Unusual Birth Circumstances: If yes, Please explain	<input type="radio"/> Yes	<input type="radio"/> No
Feeding Difficulties: If yes, Please explain	<input type="radio"/> Yes	<input type="radio"/> No
Age of Developmental milestones:		
Roll Over_____	Smile_____	Sit up_____
First steps_____	Toilet training_____	Babbling_____
First words_____	Combining words_____	
	Using sentences_____	

MEDICAL REPORTS AND DIAGNOSES:
Treatments, if any:
Illnesses:
Allergies:
Hearing and Vision Testing:

PRESENT SCHOOL PLACEMENT:	
Siblings Names: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Siblings Ages: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Mother's Occupations:	Father's Occupations:
Please list the names and relationships of family members and friends that interact with your child:	
Please list any pets and their names:	
Religious Observances:	

PARENT QUESTIONNAIRE

LIST UP TO FOUR CONCERNS THAT YOU HAVE REGARDING YOUR CHILD'S DEVELOPMENT. 1. _____ 2. _____ 3. _____ 4. _____
List up to four strengths that you observe in your child. 1. _____ 2. _____ 3. _____ 4. _____
What information do you wish to get from this evaluation

SPEECH-LANGUAGE INFORMATION

HOW OLD WAS YOUR CHILD WHEN YOU NOTICED DIFFICULTY WITH SPEECH? _____

Has your child been evaluated? **Yes** **No**

If yes, by whom? _____

Please describe the nature and results of previous or ongoing speech-language therapy.

Did your child's speech problem cause any adverse comments from relatives or acquaintances? **Yes** **No**

If so, were such comments made in your child's presence? **Yes** **No**

List any behavioral tendencies that you believe are associated with your child's speech difficulty.

1. _____
2. _____
3. _____
4. _____
5. _____

Are there any family members who have experienced speech or language difficulties? **Yes** **No**

Please explain.

Is there a foreign language spoken in the home? **Yes** **No**

If so, what language? _____

Does your child make eye contact? **Yes** **No**

If so, how and when does this occur? _____

What types of facial expressions does your child exhibit?

WHAT GESTURES DOES YOUR CHILD USE FOR COMMUNICATION?

What words and commands does your child seem to understand?

What objects and/or toys does your child use?

How does your child let you know his/her wants?

How does your child get you to do something?

How does your child get you to play games?

What does your child do to get your attention?

How does your child signal feelings?

Does your child make noises during play (e.g. motor noises, animal sounds, and conversational-like talk)?

How does your child tell about objects or events?

Does your child report to you about things that occur outside of the immediate setting?

Does your child ask for information (e.g. names, labels and locations)?