THE DYSLEXIA DEN
660-858-8336
thedyslexiaden@gmail.com
Empowering and encouraging young readers.

Speech, Language, & Literacy Case History & Intake Form

Date:_____

Patient Identification

Patient's First and Last Name: _____

Patient's Date of Birth: _____ Language(s) Spoke in the Home: _____

Name of person completing the form: _____

Relationship to child: _____

Patient Lives With: ☐ Natural Parents ☐ One Parent ☐ Parent and Step Parent

☐ Other: _____

Patient's Home Address: _____

City/State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____

Preferred Form of Communication: ☐ Phone Call ☐ Text Message ☐ Email

Describe the reason for referral and concerns: _____

_____

_____

_____

_____

_____

Patient's Primary Care Physician: _____

Who referred you to The Dyslexia Den?: _____

Family Information & History

	Name	Occupation	Highest Level of Education
Parent/Guardian #1:			
Parent/Guardian #2:			
Parent/Guardian #3:			
Parent/Guardian #4:			

THE DYSLEXIA DEN
660-858-8336
thedyslexiaden@gmail.com
Empowering and encouraging young readers.

Siblings/Other Family Members:

Name	Gender	Age	School Grade	Speech/Literacy Difficulties

Family history of the following (please list family member(s) impacted: father, mother, grandmother, grandfather, sibling, aunt, uncle, cousin, etc.):

☐ Dyslexia _____ ☐ Learning Disability _____

☐ Speech Disorder/Delay _____ ☐ Language Disorder/Delay _____

☐ ADD/ADHD _____ ☐ Autism _____

☐ Participation in Special Education _____

☐ Other _____

Is there any other relevant family or home environment information you would like to share? _____

_____

Pregnancy/Birth History

Mother's health during pregnancy and delivery: Poor Fair Excellent

1 2 3 4 5

If rated fair (3) or below, explain: _____

Delivery Method: ☐ Natural ☐ Caesarean Section

Explain: _____

Child's health during pregnancy and at delivery: Poor Fair Excellent

1 2 3 4 5

If rated fair (3) or below, explain: _____

Length of Pregnancy (weeks): _____ Baby's Birth Weight: _____

Length of hospital stay: _____ If extended stay, please explain: _____

_____

THE DYSLEXIA DEN
660-858-8336
thedyslexiaden@gmail.com
Empowering and encouraging young readers.

Developmental Milestones & Skills

Give the age the child did the following:

Sat Alone: _____ Crawled: _____ Walked Alone: _____

Fed Self: _____ Potty Trained: _____ Said First Word: _____

Combined Two Words ("want milk" "me go"): _____

Spoke in Simple Sentences (three or more words): _____

List any early developmental concerns: _____

_____

Do you or others have difficulty understanding the child's speech? Y N

Explain: _____

Explain the child's response/behaviors when others have difficulty understanding him/her? _____

_____

At any point did the child stop speaking? Y N If yes, please explain: _____

_____

Any feeding/eating problems from birth to present (biting, swallowing, sensory/texture aversions)? Y N

If yes, please explain: _____

_____

Child's dominate hand: ☐ Right ☐ Left ☐ Ambidextrous ☐ Late establishing a dominate hand

Present or previous difficulty with or poor skills in the following areas (check all that apply):

☐ Learning the names of letters ☐ Learning the sounds of letters ☐ Letter/Number reversals (b/d, 9/6)

☐ Rhyming ☐ Identifying left and right ☐ Directionality (easily gets lost)

☐ Awkward pencil grasp ☐ Learning to tie shoes ☐ Reading an analog clock

☐ Following multiple step directions ☐ Poor short-term/working memory ☐ Poor organizational skills

☐ Shortening or leaving off parts ("mote" for remote, "puter" for computer)

☐ Poor grammar ("runned" for ran, "gooses" for geese)

☐ Pronouncing words ("buskettie" for spaghetti, "mawn lower" for lawn mower)

☐ Word finding (difficulty being specific; uses phrases such as "thingie" and "You know what I'm talking about.")

Medical History

Describe the child's current health status: _____

_____

Describe any serious medical illnesses, injuries, surgeries, falls, and/or hospitalizations: _____

_____

THE DYSLEXIA DEN
660-858-8336
thedyslexiaden@gmail.com
Empowering and encouraging young readers.

History of (check all that apply):

☐ ADD/ADHD	☐ Anxiety	☐ Asthma	☐ Autism	☐ Diabetes
☐ Dental Problems	☐ Depression	☐ Encephalitis	☐ Epilepsy	☐ Frequent Colds
☐ Head Injury	☐ Heart Problem	☐ High Fevers	☐ Insomnia	☐ Measles
☐ Meningitis	☐ Migraines	☐ Mumps	☐ OCD	☐ ODD
☐ PTSD	☐ Seasonal Allergies	☐ Sensory Disorder	☐ Sleep Disorder	☐ Stroke
☐ TBI	☐ Tongue Tie	☐ Tonsilitis	☐ Trauma	☐ Vision Problems

☐ Other Syndromes or Diagnoses: _____

List any food or environmental allergies: _____

List any daily medications and dosages: _____

_____

Did the child pass the newborn hearing screening? Y N

History of hearing loss? Y N If yes, explain: _____

_____

History of ear infections? Y N If yes, circle frequency: 1 2 3 4 5 Other: _____

Treatment for ear infections: ☐ Antibiotics ☐ Tubes ☐ Surgery

Has the child received medical treatment for ear or hearing problems other than tubes? Y N

If yes, explain: _____

Date of most recent hearing screening/evaluation: _____ Results: ☐ Pass ☐ Fail

Location/Facility of hearing screening/evaluation: _____

Describe any current concerns with hearing or ear health: _____

_____

Has the child previously participated in any of the following therapies?

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Therapy Experience #1: Location/Facility of therapy: _____

Therapy start date (month/year): _____ Therapy end date (month/year): _____

Goals of therapy: _____

_____

Therapy Experience #2: Location/Facility of therapy: _____

Therapy start date (month/year): _____ Therapy end date (month/year): _____

Goals of therapy: _____

_____

Therapy Experience #3: Location/Facility of therapy: _____

Therapy start date (month/year): _____ Therapy end date (month/year): _____

Goals of therapy: _____

_____

Other relevant medical information: _____

_____

Education History

The child receives education through:

☐ Public School ☐ Private School ☐ Home School

Current School District: _____ School Building: _____

School Address (City/State only): _____

Teacher: _____ Grade: _____

Has the child repeated any grades? Y N If yes, which grades? _____

Has the child's school attendance been regular? Y N If no, explain: _____

_____

Rate Academic Performance: Poor Fair Excellent

1 2 3 4 5

Describe areas of academic strength: _____

_____

Describe areas of academic weakness: _____

_____

Describe family's academic and/or speech and language concerns: _____

_____

_____

Does the child have a history of participation if the Missouri First Steps program? Y N

Has the child ever been evaluated for special education services? Y N

Does the child currently have an Individual Education Plan (IEP)? Y N

If yes, describe current IEP goals: _____

_____

Does the child currently receive accommodations through a 504 Plan? Y N

If yes, describe current 504 Plan accommodations: _____

_____

Does the child currently receive any other services (Title Reading, Title Math, speech therapy, tutoring)? Y N

If yes, describe services being received: _____

_____

Was the child identified by the school as being at risk for dyslexia or other reading difficulties? Y N

Check all behaviors that apply:

- ☐ Fears or avoids reading aloud
- ☐ Difficulty finishing tests and assignments on time
- ☐ Avoids school
- ☐ Attempting to complete homework leads to arguments or the child becoming upset
- ☐ Complains about school more than expected
- ☐ Takes a long time to complete homework
- ☐ Often in trouble at school/being sent out of the room

Describe any other school behaviors or areas of concerns: _____

_____

Additional Relevant Information

List the child's hobbies and interests: _____

_____

_____

_____

Additional relevant information worth sharing: _____

_____

_____

_____

_____

Parent/Legal Guardian Signature: _____