DATE:_____ LAST NAME: _____ FIRST NAME: _____

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PATIENT INFORMATION

Name: _____ Date of Birth (DOB): _____ Gender: _____

Preferred Name: _____ Age: _____

Patient's Social Security #: _____

Parent's marital status? _____

List adults, siblings and ages of people in the patient's home:

_____

_____

_____

_____

Pediatrician/Physician: _____

Phone: _____ Fax: _____

Referred By: _____

Reason for Referral: _____

PARENT/GUARDIAN INFORMATION

PRIMARY

Responsible Party's Name: _____ DOB: _____

Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

E-mail Address: _____

Employer: _____ Position: _____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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PARENT/GUARDIAN INFORMATDN-CONT'D

SECONDARY

Responsible Party's Name: _____ DOB: _____

Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

E-mail Address: _____

Employer: _____ Position: _____

PATIENT HISTORY

Some of these questions may not reflect the age of the person you are describing. Please enter, "NA" if a question does not pertain to your child. You may add narrative to the back of this form to be more specific on your child.

Please list any food allergies or sensitivities: _____

food allergies

_____

Current Medications, both prescribed and over the counter (Drug Name, Dosage, Reason for Medication):

1. Drug Name: _____

Dosage: _____ Reason: _____

2. Drug Name: _____

Dosage: _____ Reason: _____

3. Drug Name: _____

Dosage: _____ Reason: _____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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PATIENT HISTORY-CONT'D

List all ***current*** therapies/treatments (speech, OT, PT, ABA, special diets, bio medical, etc.)

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

List all ***previous*** therapies/treatments (speech, OT, PT, ABA, special diets, bio medical, etc.)

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Therapy Type: _____ Provider: _____ Dates: _____

Is there additional information you would like us to know regarding current/previous therapies/treatments?

_____

_____

_____

_____

_____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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BIRTH HISTORY

MOTHER'S HISTORY

Has the mother experienced previous miscarriages? ☐ YES ☐ NO

If so, how many? _____

Is the child adopted? ☐ YES ☐ NO

If so, age at adoption? _____ Country of Birth? [1] _____

PREGNANCY, LABOR & DELIVERY

Mother's age at delivery: _____ Was the child: ☐ PREMATURE ☐ FULL TERM

Length of Gestation: _____

Infections or illness during pregnancy? ☐ YES ☐ NO

Describe:

_____

Were there shocks or abnormal stress during the pregnancy? ☐ YES ☐ NO

Describe:

_____

Did the mother's water break 24 hours before delivery? ☐ YES ☐ NO

Describe:

_____

Did the mother develop toxemia or high blood pressure? ☐ YES ☐ NO

Describe:

_____

Did the mother have any complications during labor and/or delivery?

☐ YES ☐ NO

Describe:

_____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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BIRTH HISTORY-CONT'D

Was the patient premature? ☐ YES ☐ NO

If so, how many weeks? _____

Small for gestational age? Birth weight? _____

Weight when discharged from hospital? _____

Required intensive care / hospitalization? ☐ YES ☐ NO

If so, how long & why? _____

Respiratory issues? ☐ YES ☐ NO Required a respirator? ☐ YES ☐ NO

If so, how long & why? _____

Jaundiced? ☐ YES ☐ NO If so, how long? _____

Did the child experience birth injuries? ☐ YES ☐ NO

Describe: _____

Apgar Score: 1 Minute _____ 5 Minutes _____

Birth defects? ☐ YES ☐ NO

Describe: _____

Surgeries at birth? ☐ YES ☐ NO

Describe: _____

Feeding problems at birth? ☐ YES ☐ NO

Describe: _____

Require a transfusion or exchange? ☐ YES ☐ NO

Describe: _____

Have congenital abnormalities? ☐ YES ☐ NO

Describe: _____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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BIRTH HISTORY-CONT'D

Answer "yes" or "no" to the following questions regarding the patient's birth:

YES	NO		YES	NO	
☐	☐	Cesarean Section?	☐	☐	Require forceps?
☐	☐	Require Pitocin?	☐	☐	Require a fetal monitor?
☐	☐	Breech (feet first)?	☐	☐	Insufficient oxygen?
☐	☐	Face presentation?	☐	☐	Cry right away?
☐	☐	Transverse (sideways)?	☐	☐	Heart defects?
☐	☐	Cord around neck?	☐	☐	Experience seizures?

BEHAVIOR / TEMPERAMENT

List any behavior issues such as aggression, hitting, biting, tantrums, extreme mood changes, etc.: _____

_____

What has been the best way of dealing with these issues? _____

_____

_____

List some of your child's favorite items, foods and things to do: _____

_____

_____

Is there additional information you would like us to know regarding your child's behavior/temperament? _____

_____

_____

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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& ASSOCIATES

TASTE AND SMELL

Answer “yes”, “no” or “used to” to the questions below regarding patient’s taste and smell.

YES	NO	USED TO	
☐	☐	☐	Acts as though all foods taste the same?
☐	☐	☐	Avoids or craves certain foods?

Describe: _____

☐	☐	☐	Chews on non-food items?
☐	☐	☐	Experiences feeding problems?

Describe: _____

☐	☐	☐	Had trouble changing to textured foods?
☐	☐	☐	Sensitivity to unusual smells?
☐	☐	☐	Tastes or smells toys, clothes, etc. more than usual?
☐	☐	☐	Seems to be a picky eater?

Describe: _____

MUSCLE TONE

Answer “yes”, “no” or “used to” to the questions below regarding patient’s muscle tone.

YES	NO	USED TO	
☐	☐	☐	Has diagnosed muscle problems?

Describe: _____

☐	☐	☐	Feels heavier than they look?
☐	☐	☐	Has good endurance?
☐	☐	☐	Has flat feet?
☐	☐	☐	Slumps when siting?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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MUSCLE TONE-CONT'D

YES	NO	USED TO	
☐	☐	☐	Tires easily?
☐	☐	☐	Seems generally weak?
☐	☐	☐	Keeps mouth open?
☐	☐	☐	Preferred lying on back rather than tummy as an infant?

COORDINATION AND DEVELOPMENT

Child's age for independent:

Sitting:_____ Crawling:_____ Standing:_____ Walking:_____

Answer "yes", "no" or "used to" to the questions below regarding patient's coordination and development.

YES	NO	USED TO	
☐	☐	☐	Unusually prolonged creeping and crawling?
☐	☐	☐	Movements are slow, plodding and deliberate?
☐	☐	☐	Difficulty with sequential tasks such as dressing?
☐	☐	☐	Difficulty holding pencil/crayon with a mature grasp?
☐	☐	☐	Creeps on tummy or bottom?
☐	☐	☐	Plays clumsily with toys?
☐	☐	☐	Often trips or falls?
☐	☐	☐	Seems clumsy or awkward?
☐	☐	☐	Bumps into things often?
☐	☐	☐	Has poor handwriting?
☐	☐	☐	Eats neatly for their age?
☐	☐	☐	Has rigid movements?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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COORDINATION AND DEVELOPMENT-CONT'D

YES	NO	USED TO	
☐	☐	☐	Hands get shaky in fine motor development?
☐	☐	☐	Enjoys sports or gym time?

AUDITORY

Answer "yes", "no" or "used to" to the questions below regarding patient's auditory ability.

YES	NO	USED TO	
☐	☐	☐	Fear or any particular sound?

Describe: _____

☐	☐	☐	Diagnosed with hearing problems?
☐	☐	☐	Frequent ear infections?
☐	☐	☐	Tubes in ears? If so, still present? YES NO
☐	☐	☐	Sensitive to sound?
☐	☐	☐	Responds negatively to unexpected sounds?
☐	☐	☐	Distracted by sounds from refrigerator, fans, etc.?
☐	☐	☐	Seems confused about the direction sounds come from?
☐	☐	☐	Likes to make loud noises?
☐	☐	☐	Difficulty repeating rhythmical sounds?
☐	☐	☐	Fails to follow through/act upon verbal instructions?
☐	☐	☐	Unable to follow 2-3 part commands if given at once?
☐	☐	☐	Talks excessively
☐	☐	☐	Talking interferes with listening?
☐	☐	☐	Has a speech/language disorder?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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TACTILE

Answer “yes”, “no” or “used to” to the questions below regarding patient’s tactile ability.

YES	NO	USED TO	
☐	☐	☐	Seems overly sensitive to different food textures?

Describe: _____

☐	☐	☐	Likes to be touched?
☐	☐	☐	Disliked to be held or cuddled?
☐	☐	☐	Prefers to touch rather than be touched?
☐	☐	☐	Seems excessively ticklish?
☐	☐	☐	Easily irritated or enraged when touched?
☐	☐	☐	Has a strong need to touch objects or people?
☐	☐	☐	Seems to pick fights?
☐	☐	☐	Overheats easily?
☐	☐	☐	Seems overly sensitive to food/water temperature?
☐	☐	☐	Prefers tub baths over showers if given a choice?
☐	☐	☐	Likes to play in water, sand, mud or clay?
☐	☐	☐	Seems to lack the normal awareness of being touched?
☐	☐	☐	Often seems unaware of cuts & bruises?
☐	☐	☐	Avoids using hands?
☐	☐	☐	Examines objects or clothes with their hands?
☐	☐	☐	Walks on toes?
☐	☐	☐	Dislikes haircuts or nail trimmings?
☐	☐	☐	Chews on objects or clothes?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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VESTIBULAR

Answer “yes”, “no” or “used to” to the questions below regarding patient’s vestibular ability.

YES	NO	USED TO	
☐	☐	☐	Arched back when held or moved as an infant?
☐	☐	☐	Enjoys being rocked?
☐	☐	☐	Likes being tossed in the air?
☐	☐	☐	Likes fast spinning carnival rides?
☐	☐	☐	Likes to swing?
☐	☐	☐	Spins or twirls more than other children?
☐	☐	☐	Gets car sick easily?
☐	☐	☐	Gets nauseous and/or vomits from movement experiences?
☐	☐	☐	Rocks while sitting?
☐	☐	☐	Jumps a lot?
☐	☐	☐	Has a fear of space (stairs, heights, crawl tunnels)?
☐	☐	☐	Easily loses balance?
☐	☐	☐	Misunderstands the meaning of words used in relation to movement & direction?

VISUAL

Answer “yes”, “no” or “used to” to the questions below regarding patient’s visual ability.

YES	NO	USED TO	
☐	☐	☐	Has a diagnosed visual problem?

Describe: _____

☐	☐	☐	Overly sensitive to light?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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VISUAL-CONT'D

YES	NO	USED TO	
☐	☐	☐	Has trouble following with eyes?
☐	☐	☐	Avoids eye contact?
☐	☐	☐	Distracted by visual contact?
☐	☐	☐	Dislikes having eyes covered?
☐	☐	☐	Able to close eyes for short periods of time?
☐	☐	☐	Makes reversals when copying or reading?
☐	☐	☐	Prefers playing in the dark?
☐	☐	☐	Has trouble discriminating shapes or colors?
☐	☐	☐	Squints often?
☐	☐	☐	Able to look at things far away?
☐	☐	☐	Able to look at things close by?
☐	☐	☐	Blinks or turns away when a ball is thrown at them?

DATE:_____ LAST NAME: _____ FIRST NAME: _____

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NO SHOWS AND CANCELLATIONS

As professionals we set aside therapy time for you and request that you be respectful of our time and yours. Appointments not cancelled within 24 hours will be charged a fee of half the session, up to two hours proper. Appointments not cancelled at all are considered a "no show" and are charged at the full rate for that session.

There certainly can be exceptions to this policy such as such children becoming ill, etc. but it is your responsibility to contact the Speech-Language Pathologist that works with your child as soon as possible to eliminate any extra fees. If your child is sick on one day of therapy, please call each day that they are to be in therapy if they are still ill.

Name of parent/guardian: _____

Child's name: _____

Date: _____