Speech Pathways

Therapy Services for Pediatrics and Adults

İNTAKE FORM

DEMOGRAPHİC İNFORMATİON

Child's Name ____ Date of Birth __________________

Child's nickname (if applicable)___________________________ Gender ___________ Age _________

Parent/Guardian _______________________________________ Home Phone__________________

Address____ Cell Phone of Mother______________

City/State/Zip____ Cell Phone of Father_______________

E-Mail Address ____ Work Phone_____________________

Siblings __________________________ Age____ Siblings ____________________________ Age____

Siblings __________________________ Age____ Siblings ____________________________ Age____

Emergency Contact: ____________________________________ Phone__________________________

Reason for Referral/Concern____

____

İNSURANCE İNFORMATİON

Provider ____________________________________ Employer's Name __________________________

İnsured's Group/FECA/MEDİCARE # _____________________________İnsured's İD/SS# _____________

Child's Relationship to İnsured ____

MEDİCAL İNFORMATİON

Primary Care Physician____Phone________________

Address____

Medical Specialists (if any)

Name____
Specialty___________________________

Name____
Specialty__________________________

Name____
Specialty___________________________

HEALTH AND DEVELOPMENTAL HİSTORY

Maternal History

Did mother take medication during pregnancy? (Please specify what, why and for how long)

____

____

____

Did any of the following occur during pregnancy?

___Bleeding_______________________________________

___Measles____

___İllness/İnfections________________________________

___Rashes____

___Rh incompatibility of parents__________________

Birth History

Length of pregnancy (weeks) ___________Labor induced _____________ Forceps used________

Birth weight_________________ Apgar Score___________________ Length of Labor____________

Any medications given during birth and to whom ____

Explain any significant occurrences during the child's birth (i.e., trauma, cord wrapped around neck, jaundice, heart issues, feeding problems, need for medical attention/oxygen) ___________________

____

HEALTH HİSTORY

Has the child's health been good, fair, or poor? ____

Please circle any of the following occurrences:

Ear İnfections	Eczema	Constipation	Allergic Reactions
Tubes in Ears	Asthma	Special diet	
Reflux	RSV/Pneumonia	Seasonal Allergies	

Takes medicine regularly (frequency/reason)____

Hospitalizations____

Surgeries____

Developmental History

At what age did the child reach the following developmental milestones?

Sit unsupported________ Crawl___________ Walk___________ Bladder Control________________

Bowel Control__________ Feed Self_________Stand_________ Dress Self______________________

Begin saying words_________ Combine words____________

Answer questions/relate information verbally________________

Compared to sibling or peers, was speech development fast, slow or average__________________

Does the child seem to be aware of his/her speech-language challenges_______________________

How does the child usually communicate? (Gestures, signs, single words, phrases, sentences)

How much do you understand your child's speech ____

Do others understand your child's speech_________________ How much_______________________

Languages used:

At Home ___________________________________ At School___________________________________

Primary Language child uses____

Concerns (Please check all that apply)

___Hearing (has a hearing loss, seems to not hear information, need repetition)

___ Speech Articulation (difficult to understand or poor sound production)

___Expressive Language Skills (unable to relay thoughts or express needs clearly)

___ Receptive Language Skills (difficulty following directions or concepts)

___ Oral Motor Functioning (drooling, tongue thrust, muscle strength)

___Swallowing/Feeding (cough/chokes with food, decreased chewing)

___Other (Please Explain) ____

ASSOCİATED İLLNESS OR DİSORDERS

(Please check all that apply and indicate M-mother, F-Father, S-sibling of child, or R-other relative)

___ Hearing Loss ___ İntellectual Disability

___ Clinical Depression ___ Mental İllness

___ Autism ___ Alcoholism/Drug Abuse

___ Seizures/Epilepsy ___ Other (please specify) ____________________________________

EDUCATİONAL AND SOCİAL HİSTORY

İs the child currently attending a school or preschool_________ Name_________________________

Grade___________________ Teacher____

How is your child doing academically or preacademically___________________________________

How does your child interact with others? (Shy, aggressive, uncooperative, outgoing, and friendly)

____

Previous/current therapy providers through school or any other setting:

Name____________________________Service__________________________Date _____________

Name____________________________Service__________________________Date _____________

Name____________________________Service__________________________Date _____________

Please circle the most appropriate response that describes your child

(Frequently (F), Occasionally (O) Never (N))

İs distracted/has trouble functioning with noise present.................................. F O N

Does not hear what you say (tunes you out or ignores you............................ F O N

Does not respond when name is called.. F O N

Cries or covers ears when loud noises are present.. F O N

Enjoys music and noise and uses it to calm down... F O N

FEEDİNG/ORAL-MOTOR HİSTORY

Was the child breast fed________ How long______ Bottle fed _______ How long _________

Has/does the child currently display any of the following difficulties?

Choking/gagging _____ Over stuffing of food _____ Spits out food _____

Drooling_____ Special diet _____ Poor chewing _____

Swallows food whole_____ Sticks tongue out when eating _____ Food allergies _____

Difficulty using straw/cup_____ Spillage from mouth _____

Dislikes face washing _____ Hates brushing teeth _____

Bites/chew on non-food items _____

Food textures preferences (Please circle all that apply)

Crunchy	Salty	Cold	Sour	Hot	Sweet	Warm
Pureed	Spicy	Room Temp	Semi-Solid	Thick Liquid		

ALLERGİES/Food restrictions____