Date:____/____/_____

☐ MALE ☐ FEMALE

PATIENT'S NAME (LAST, FIRST) | **DATE OF BIRTH**

STREET ADDRESS | **CITY** | **STATE** | **ZIP CODE**

HOME PHONE NUMBER | **EMAIL ADDRESS FOR RECEIPTS**

FATHER'S/GUARDIAN'S NAME | **DATE OF BIRTH** | **CELL PHONE NUMBER** | **SOCIAL SECURITY NUMBER**

EMPLOYER | **POSITION** | **PHONE NUMBER**

MOTHER'S/GUARDIAN'S NAME | **DATE OF BIRTH** | **CELL PHONE NUMBER** | **SOCIAL SECURITY NUMBER**

EMPLOYER | **POSITION** | **PHONE NUMBER**

PRIMARY CARE PHYSICIAN | **PHONE NUMBER** | **REFERING PHYSICIAN** | **PHONE NUMBER**

DO YOU HAVE A PERSCRIPTION? ☐ **YES** ☐ **NO**

Parent/Guardian Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other

Child lives with (check one): ☐ Birth Parents ☐ One Parent ☐ Parent and Step Parent ☐ Foster Parents ☐ Adoptive Parents ☐ Other_____

Child's race/ethnic group: ☐ Caucasian, Non-Hispanic ☐ African-American ☐ Hispanic ☐ Asian or Pacific Islander ☐ Native American ☐ Other_____

Is there a language other than English spoken in the home? ☐ Yes ☐ No If yes, which one?_____

How did you hear about us?_____

Describe your child's strong likes:_____

Describe your child's strong dislikes:_____

What is your child's favorite toy/activity:_____

Insurance Information

*Primary Insurance Name:*_____ Phone# _____

ID#:_____ Group#_____ Effective Date:_____

Subscriber's Name*:*_____

*Secondary Insurance Name:*_____ Phone# _____

ID#:_____ Group#_____ Effective Date:_____

Subscriber's Name:_____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

BIRTH HISTORY

Baby was delivered: ☐ Full-Term ☐ Premature (_____week of gestation)

Type of delivery: ☐ Cesarean ☐ Vaginal ☐ Breech

This was a: ☐ Single Birth ☐ Multiple Birth (twins, triplets, etc)

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No
If yes, please describe._____

_____

At birth the infant weighed:_____ Apgar scores (if known)_____

Did the baby pass the newborn hearing screening? ☐ Yes ☐ No

Did the baby experienced difficulties breathing? ☐ Yes ☐ No

Did the baby experience jaundice? ☐ Yes ☐ No

Was the baby placed on a feeding tube? ☐ Yes ☐ No

Was the mother and infant discharged separately from the hospital? ☐ Yes ☐ No

Please explain any YES answers: _____

_____

Did the baby experience any early feeding/swallowing problems such as a weak suck, projectile vomiting, lack of appetite, early fatigue, etc)? _____

_____

MEDICAL HISTORY

Has your child had any of the following?

☐ Adenoidectomy	☐ Encephalitis	☐ Seizures	☐ Chicken pox
☐ Allergies	☐ Flu	☐ Sinusitis	☐ High Fevers
☐ Breathing difficulties	☐ Head Injury	☐ Sleeping difficulties	☐ Thumb/finger sucking habit
☐ Colds	☐ Measles	☐ Tonsillectomy	☐ Tonsillitis
☐ Mumps	☐ Meningitis	☐ Vision Problems	☐ Pneumonia

☐ Ear infections How many? _____

☐ Ear tube placement When? _____

Other serious injury or surgery:_____

_____

_____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Is your child currently under physician's care? ☐ Yes ☐ No If yes, why?_____

_____

Please list any medications your child (please include purpose of the medication)?_____

_____

_____

Does your child have any known allergies to food or to the environment? ☐ Yes ☐ No

If yes, please list_____

Does your child have any medical diagnoses? (e.g. ADD, Autism, dyslexia, CP) ☐ Yes ☐ No

_____

Date of last hearing test:_____ Agency:_____Results:_____

DEVELOPMENTAL MILESTONES

Please tell the approximate age your child achieved the following developmental milestones:

_____ rolled over	_____ babbled
_____ sat up without support	_____ said first word
_____ crawled	_____ put 2 words together
_____ cruised furniture	_____ spoke short sentences
_____ walked	_____ toilet trained

EDUCATIONAL HISTORY

Name of school/daycare currently attending: _____

Address_____

Present Grade_____ Does your child have an IEP? ☐ Yes ☐ No

Please complete the following concerning professionals currently working with your child:

Service Provided	Name of Provider	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHOTO PERSMISSION

	Initial
1. I give permission for photographs/videotape of my child for the purpose of treatment, education, and documentation.	_____
2. I give permission for photographs/videotape of my child for website/Facebook.	_____

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge receipt of the Notice of Privacy Practices for ABC Pediatric Therapy, LLC. I hereby consent to the use and disclosure of my child's protected health information (PHI) for the purpose of evaluation, treatment, payment, and health care coordination.

Initial:_____

Thank you for your time in filling out this information regarding your child.

Completed by: _____ Relationship: _____ Date:_____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Speech and Language Information

What is your main concern with your child's speech and language? _____

_____

_____

Please list any relevant family history (speech/language/motor delays). _____

_____

_____

Has your child ever had a speech/language evaluation? ☐ Yes ☐ No

If yes, where and when?_____

What were you told? _____

_____

Indicate with a checkmark any items that are difficult for your child:

☐ Eating a variety of food	☐ Understanding what he/she hears
☐ Following directions	☐ Speaking in grammatically correct sentences
☐ Answering questions	☐ Pronouncing words correctly
☐ Stating sounds of letters	☐ Recognizing "common" words
☐ Rhyming	☐ Getting their point across
☐ Telling stories	☐ Thinking of words for things
☐ Self-calming	☐ Understanding concept of time

How would you describe your child's primary method of communication?

☐ Vocalizing/Grunting ☐ Pointing/Gestures ☐ Single Words ☐ Sentences

Which of the following best describes your child's speech?

☐ Non-Verbal ☐ Easy to Understand ☐ Difficult for family to understand ☐ Difficult for others to understand

Feeding:

Does your child…

Eat with spoon and fork	☐ Yes ☐ No	Drink from an open cup	☐ Yes ☐ No
Drink from a straw	☐ Yes ☐ No	Drool	☐ Yes ☐ No
Cough/gag while eating	☐ Yes ☐ No	Pocket food in mouth	☐ Yes ☐ No

Have difficulty chewing meats or solid foods ☐ Yes ☐ No

Present as a picky eater ☐ Yes ☐ No

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Sensory Motor Information

Please check any statement that describes your child:

___ Frequently trips on his/her own feet

___ Walks on his/her toes

___ Frequently bumps into furniture, walls, or other people

___ Needs cues to wipe face or hands when dirty

___ Has trouble sitting still

___ Chews on things such as his/her shirt, pens, toys

___ Avoids certain textures. If yes, which ones? _____

___ Gets "stuck" on toys/tasks/ideas and has a difficult time changing to another toy/task/idea.

___ Has trouble sleeping