Total Health
OFFERED BY STILLWATER MEDICAL CENTER

Intake Speech Pediatric

GENERAL INFORMATION:

DATE: ____ /____ /_____

PATIENT NAME:		DATE OF BIRTH:
MOTHER'S NAME:		
MOTHER'S CONTACT INFO: HOME #:	CELL #:	WORK #:
FATHER'S NAME:		
FATHER'S CONTACT INFO: HOME #:	CELL #:	WORK #:
MOTHER'S EMAIL ADDRESS:	FATHER'S EMAIL ADDRESS:	
MAY WE CALL YOU DURING THE DAY? ☐ YES ☐ NO	IF YES, WHO SHOULD BE CALLED? ☐ MOTHER ☐ FATHER	
WHO WILL BRING THE CHILD TO THERAPY? NAME:		RELATIONSHIP:
OTHER CAREGIVER'S INVOLVED:		
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:	
RETURN TO DOCTOR DATE:	ONSET DATE OF SYMPTOMS:	
BROTHER AND SISTERS: (PLEASE LIST NAMES AND AGES)		

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY
CURRENT PATIENT INFORMATION:

- What languages does the child speak? What is the child's dominant language? _____
- What languages are spoken in the home? What is the dominant language spoken? _____
- With whom does the child spend most of his or her time? _____
- Describe the child's speech-language problem? _____
- How does the child usually communicate (gestures, single words, short phrases, sentences)? _____
- When was the problem first noticed? By whom? _____
- What do you think may have caused the problem? _____
- Has the problem changed since it was first noticed? _____
- Is the child aware of the problem? If yes, how does he or she feel about it? _____

- Have any other speech-language specialist seen the child? Who and when? What were their conclusions or suggestions? _____

_____

- Have any other specialists (physicians, audiologist, psychologist, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions? _____

_____

_____

_____

- Are there any other speech, language, or hearing problems in your family? If yes, please describe._____

_____

_____

PRENATAL AND BIRTH HISTORY:

- Mother's general health during pregnancy (illnesses, accidents, medications, etc.)? _____

_____

_____

- Length of pregnancy: _____ • Length of labor: _____
- General condition: _____ • Birth weight: _____
- Type of delivery: ☐ Head first ☐ Feet First ☐ Breech ☐ Caesarian
- Were there any unusual conditions that may have affected the pregnancy or birth? _____

_____

MEDICAL HISTORY:

- Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma _____	Chicken Pox _____	Colds_____
Croup_____	Dizziness_____	Draining ear _____
Ear infections _____	Encephalitis _____	German Measles _____
Headaches_____	High fever_____	Influenza _____
Mastoiditis _____	Measles_____	Meningitis_____
Mumps_____	Pneumonia _____	Seizures _____
Sinusitis_____	Tinnitus_____	Tonsillitis _____

Other:_____

- Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?_____

_____

_____

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_____

- Describe any major accidents or hospitalizations:_____

_____

_____

_____

- Is the child taking any medication? If yes, identify: _____

_____

_____

_____

- Have there been any negative reactions to medications? If yes identify: _____

_____

_____

_____

DEVELOPMENTAL HISTORY:

- Provide the approximate age at which the child began to do the following activities:

  Crawl _____ Sit _____ Stand _____

  Walk _____ Feed self _____ Dress self _____

  Use toilet _____

  Use single words (e.g., no, mom, doggie) _____ Combine words (e.g., me go, daddy shoe) _____

  Name simple objects (e.g., dog, car, tree) _____ Use simple questions (e.g., Where's doggie) _____

  Engage in a conversation _____
- Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? _____
- Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe: _____
- Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds). _____

EDUCATIONAL HISTORY:

- School: _____ Grade: _____

  Teacher(s): _____
- How is the child doing academically (or preacademically)? _____

  _____
- Does the child receive special services? If yes, describe _____

  _____
- How does the child interact with others (e.g., shy, aggressive, uncooperative)? _____

  _____
- If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals? _____
- Provide any additional information that might be helpful in the evaluation or remediation of the child's problem:

  _____

  _____

  _____

  _____

Person completing form: _____ **Relationship to patient:** _____

Signed: _____ **Date:** _____