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? ____________________

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- 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? ________

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

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PRENATAL AND BIRTH HISTORY:

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

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- 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? ____________________

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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:____________________

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

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

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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)? ____________

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

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

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- 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:

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

Signed: ____________ **Date:** ____________