Beauregard Memorial Hospital Rehabilitation Services
Pediatric Speech Pathology Intake Form

Today's Date: M/D/Yr (e.g., 03/28/2012)

Patient's Name:

Date of Birth: M/D/Yr (e.g., 03/28/2012) Age:

Gender: Male Female

Address:
Apt.
CITY: STATE: ZIP CODE:

Home Phone:
Cell Phone:
Business Phone:
Other Phone:
Email:

Does the child live with both parents? YES NO

Mother's Name: Age: Occupation:

Father's Name: Age: Occupation:

Is the child currently receiving Home Health Care or any other assistance in the home? (e.g., Early Steps/Early Intervention, Thompson Home Health, etc.).

Yes; Name of Agency: No

What is the reason for the visit today?

Primary Insurance:
I.D. #
Group #
Phone #

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Secondary Insurance:
I.D. #
Group #
Phone #

Emergency Contact :

Phone #

Referred by:

Primary Care Physician:

Referred For: Physical Therapy Occupational Therapy Speech Therapy

Does the Patient Have Any Brothers or Sisters? (**If YES, please include names and ages**).
YES NO

Sibling's Name	**Sibling's Age**

MEDICAL HISTORY

Operations and/or Other Medical Procedures; If YES, what type and when (e.g., tonsillectomy, tube placement)

YES NO

Operation and/or Other Medical Procedures	**Date:**

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Please List Current Medications:

Allergies to Any Medications:

Describe Any Major Accidents: (**Please Include Dates**):

Accident Event(s)	**Date**

Please Mark "X" Below and Provide Approximate Ages at Which the Patient Suffered the Following Illnesses and Conditions

Condition	**Mark "X"**	**Age**
Adenoidectomy		
Chicken Pox		
Croup		
Ear Infections		
Headaches		

Condition	**Mark "X"**	**Age**
Mumps		
Pneumonia		
Tinnitus		
Asthma		
Convulsions		

Influenza		
Meningitis		
Otosclerosis		
Sinusitis		
Tonsillitis		
Allergies		
Colds		
Dizziness		
Encephalitis		
Other:		
Other:		

Draining Ear		
German Measles		
High Fever		
Measles		
Noise Exposure		
Seizures		
Tonsillectomy		
Mastoiditis		
Hearing Loss		
Other:		
Other:		

When was the patient's last physician/medical visit for this problem?

When is the patient's next follow-up appointment for this problem?

Has the patient seen any other specialists (physicians, psychologists, neurologists, etc.)? If YES, indicate the type of specialist, when the patient was seen, and the specialist's conclusions or suggestions.

Type of Specialist	Date Seen	Conclusion/Suggestions/Results

SPEECH-LANGUAGE-COGNITIVE-SWALLOW HISTORY:

Who lives in the home?

What languages does the **child** speak? What is the **child's** primary language?

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Languages	Primary Language

What languages are spoken in the **home**? What is the primary language spoken in the **home**?

Languages	Primary Language

With whom does the child spend most of his or her time?

Describe the patient's speech-language-cognitive-swallow problem.

How does the child usually communicate (**gestures, single words, short phrases, sentences**)?

When was the problem first noticed? By Whom?

Age First Identified:	**By Whom:**

What do you think may have caused the problem?

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Has the problem changed since it was first noticed?

Is the child aware of the problem? If YES, please describe how he or she feels about it?
YES NO

Has the patient seen any other speech-language pathologists? If YES, please describe below.
YES NO

Speech-Language Pathologist	**Date Seen**	**Conclusion/Suggestions/Results**

Are there any other speech, language, cognitive, swallow, learning, or hearing problems **in your family**? If YES, please describe below.
YES NO

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Disorders / Conditions	Date Diagnosed	Describe: (Who in the family? Description of Problem)
Speech Disorder / Delay		
Language Disorder / Delay		
Cognitive Disorder		
Swallow Disorder		
Learning Disorder / Disability		
Hearing Problems		
Other:		
Other:		

PRENATAL AND BIRTH HISTORY

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

Length of Pregnancy:

Length of Labor:

General Condition:

Birth Weight:

Please mark "X" for type of delivery:

Head First
Feet First
Breech
Caesarian

Any unusual conditions that may have affected the pregnancy or birth? If YES, please describe.

YES NO

DEVELOPMENTAL HISTORY

(Provide the approximate age at which the child began to do the following activities)

Developmental Activities	Approximate Age
Crawl	
Sit	
Stand	
Walk	
Feed Self	
Dress Self	
Use Toilet	
Use Single Words (e.g., no, mom, doggie, etc.)	
Combine Words (e.g., me go, daddy shoe, etc.)	
Name Simple Objects (e.g., dog, car, tree, etc.)	
Use Simple Questions (e.g., Where's doggie? etc.)	
Engage in a conversation	

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? If YES; please describe.

YES NO

Are there or have there ever been any feeding problems? (e.g., If YES, please describe below.
YES NO

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.)

EDUCATIONAL HISTORY

What is the name of the child's school, teacher(s), and grade-level? (i.e., If the child is pre-academic, please list name(s) of daycare, preschool, etc.)

Name of School (e.g., K. P. Hanchey Elementary)	**Name of Child's Teacher** (e.g., Mrs. Jane Smith)	**Grade-Level** (e.g., First Grade)

How is the child doing academically (or pre-academically)?

Does the child receive special services? If YES, please describe.
YES NO

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How does the child interact with others (e.g., shy, aggressive, uncooperative, disinterested, etc.)

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed?
If YES, describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation process.
