Northeast Hospitals

The Center for Rehabilitation and Sports Medicine

You are scheduled for a speech-language-feeding evaluation on _____ at _____am/pm.

Please arrive 10-15 minutes prior to your appointment to allow time for registration. You will need to bring the following items in order to complete the evaluation:

- Medical order from your physician ordering a speech-language, feeding or voice evaluation
- Insurance card
- Any necessary insurance authorizations. Please contact the front desk or your PCP for more information
- The enclosed questionnaire
- Any other previous speech-language evaluations completed in the past to allow for comparisons and continuum of treatment
- If your evaluation is in regards to feeding or eating – please provide food and liquids that your child can and will consume.

PEDIATRIC SPEECH-LANGUAGE-FEEDING INTAKE FORM

Child's Name: _____Date of birth: _____ Age: _____

Address: _____

Phone: _____

Parent email address (optional): _____

Who would you like copies of this evaluation report to be sent to?

Why do you or the person who referred your child feel your child needs speech therapy?

What is the child's primary language? Any other languages spoke in the home?

Mother's name: _____Date of birth: _____

Mother's Occupation _____

Father's name: _____Date of birth: _____

Father's Occupation _____

Pediatrician: _____

SIBLINGS

	Name	**Age**	**Grade in school**
1.			
2.			
3.			
4.			

BIRTH HISTORY

Were there any health issues or medications taken during pregnancy?

Was the baby born to term? If not, please explain:

How was the infant delivered: Head first Feet first Breech C-Section

How much did the infant weigh at birth? _____

Were there any complications at birth?

Were there any immediate problems following the birth or during the first 2 weeks of the infant's life (health, swallowing, sucking, feeding, sleeping, etc.)? If so, describe.

PAST MEDICAL HISTORY

Please check all that apply re: your child's past medical history

- ☐ Frequent colds
- ☐ Pneumonia
- ☐ Tinnitus – ringing in the ears
- ☐ Asthma
- ☐ Allergies
- ☐ Meningitis
- ☐ Seizures
- ☐ Tonsillitis
- ☐ Ear infections
- ☐ P-E tubes for ear infections/fluid
- ☐ Sinusitis
- ☐ Surgery
- ☐ Head injury
- ☐ Hearing loss or issues
- ☐ Visual impairments
- ☐ Swallow difficulties or problems
- ☐ Cleft Palate
- ☐ Cerebral Palsy
- ☐ Intellectual Disabilities or Disorders
- ☐ Autism-PDD spectrum disorders
- ☐ Difficulty gaining weight
- ☐ Headaches
- ☐ Speech, language, or motor delay
- ☐ ADD/ADHD
- ☐ Other (see below)

Please list any other medical diagnosis or explanations from any of above:

Please list any allergies the child has:

FAMILY HISTORY

Are there any family members with speech, language, or hearing problems? If yes, please describe.

SOCIAL HISTORY

Does your child attend school or day care?

How many days/ hours does your child attend school or day care?

How is your child doing academically?

Has the child received speech therapy in the past? If yes, where? How long?

Does your child *currently* receive support services? Please indicate how often in the line provided:

☐ Speech Therapy _____ ☐ Reading specialist _____

☐ Occupational Therapy _____ ☐ Behavioral specialist _____

☐ Physical Therapy _____ ☐ Other: _____

DEVELOPMENTAL HISTORY

Did your child achieve the following developmental milestones:

	YES	**NO**
Hold his or her head up by 4 months		
Coo-Babble by 4 months		
Respond to name, play peek-a-boo type games by 8 months?		
Use jargon by 12 months? Imitate sounds by 12 months?		
First crawl by 12 months		
First walk alone by 16 months		
First sit alone by 12 months		
First ate solid food by 12 months?		
Say his/her first word by 15 months?		
Fed self by 2 years		
Put 2 words together by 2 years?		
Was toilet trained by 3 years?		
First grasped a writing utensil by 3 years?		
Start using short sentences by 3 years?		

Utilize a check mark to indicate all of the following speech-language-cognitive functions your child may experience **difficulty** with:

- ☐ Eating a variety of different foods
- ☐ Chewing/swallowing foods
- ☐ Sucking on a bottle or using a sippy cup
- ☐ Using a straw
- ☐ Blowing bubbles
- ☐ Following directions or routines
- ☐ Answering questions
- ☐ Understanding what is being said
- ☐ Recognizing common words
- ☐ Is not using words to express needs/wants or is relying on gesture to express needs/wants
- ☐ Is experiencing behavioral issues and challenges
- ☐ Vocabulary use and development is delayed
- ☐ Understanding of concepts
- ☐ Rhyming
- ☐ Delays of reading / spelling development
- ☐ Using grammatically correct sentences
- ☐ Pronouncing a variety of sounds (articulation)
- ☐ Being understood by others
- ☐ Interacting with others (socialization/pragmatics)
- ☐ Expressing thoughts
- ☐ Speaking fluently (stutter)
- ☐ Self calming or regulating
- ☐ Learning and advancing academically
- ☐ Staying organized
- ☐ Maintaining adequate breath support for voice
- ☐ Oral motor coordination
- ☐ Transitioning to new environments

Please elaborate or provide any further insight into your child's speech-language-feeding difficulty:

Describe how the child communicates best

- ☐ Pointing
- ☐ Grunting-vocalizing
- ☐ Gestures
- ☐ Sign Language
- ☐ Picture Symbols – AAC or Johnson Mayer
- ☐ Single words
- ☐ Simple phrases
- ☐ Complete sentences
- ☐ Conversation

Estimate how many word the child currently uses:

When did you first notice the speech-language-feeding delay?

Is the child aware of the problem? If yes, how does the child feel about it?

HEARING

Has you child has his/hers hearing formally evaluated? If so, where? When?

Are there any concerns regarding hearing loss?

Please provide some insight into things your child likes and dislikes so that during therapy strategies and reinforcements can be used appropriately during their time here at Northeast Hospitals.

Please provide any additional information that may be helpful in the diagnostic and treatment phase of your child's care in speech-language therapy:

_____

Parent signature Date