



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**

	<b>Name</b>	<b>Age</b>	<b>Grade in school</b>
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

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

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:

- |   |  |
|---|--|
| <input type="checkbox"/> Speech Therapy _____       | <input type="checkbox"/> Reading specialist _____    |
| <input type="checkbox"/> Occupational Therapy _____ | <input type="checkbox"/> Behavioral specialist _____ |
| <input type="checkbox"/> Physical Therapy _____     | <input type="checkbox"/> 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:

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

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

Describe how the child communicates best

- |   |   |
|---|---|
| <input type="checkbox"/> Pointing                               | <input type="checkbox"/> Single words       |
| <input type="checkbox"/> Grunting-vocalizing                    | <input type="checkbox"/> Simple phrases     |
| <input type="checkbox"/> Gestures                               | <input type="checkbox"/> Complete sentences |
| <input type="checkbox"/> Sign Language                          | <input type="checkbox"/> Conversation       |
| <input type="checkbox"/> Picture Symbols – AAC or Johnson Mayer |   |

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 your child had 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:

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Parent signature

Date