BEAUREGARD
HEALTH SYSTEM

Beauregard Health System Rehabilitation Services
Pediatric Speech Pathology Intake Form

Today's Date:

Patient's Name:

Date of Birth: Age:

Gender: ☐ Male ☐ Female

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

Please include ALL phone numbers in which you can be reached for appointment information.

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 speech problem is the patient experiencing?

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

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

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	

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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:

Please List Current 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		
Influenza		
Meningitis		
Otosclerosis		
Sinusitis		
Tonsillitis		
Allergies		
Colds		
Dizziness		
Encephalitis		

Condition	Mark "X"	Age
Mumps		
Pneumonia		
Tinnitus		
Asthma		
Convulsions		
Draining Ear		
German Measles		
High Fever		
Measles		
Noise Exposure		
Seizures		
Tonsillectomy		
Mastoiditis		
Hearing Loss		

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

Who lives in the home?

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

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?

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

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		

Are there or have there ever been any feeding problems? (If YES, please describe below.)

☐ YES ☐ NO

EDUCATIONAL HISTORY

Name of School	Name of Child's Teacher	Grade-Level

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

Does the child receive special services? If YES, please describe.

☐ YES ☐ NO

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