Lucas Speech Pathology

Pediatric Intake Form

Today's Date: _____

Personal Information:

Name: _____ D.O.B: _____ Age: _____

Address: _____ Phone: _____ (H)

_____ _____ (C)

Email: _____ Primary Language: _____

Referring Physician (name and phone #): _____

Reason for Referral: _____

_____

Medical History

Birth history (e.g.: cesarean, NICU stay, jaundiced, etc.): _____

_____

Please list any/all diagnoses: _____

_____

Current medications (including vitamins): _____

_____

Please report any recent (last 12 months) medical exams or procedures (e.g.: ENT, neurologist, GI):

_____

_____

Hearing/audiological evaluation?: yes/no Results: _____

History of Reflux?: _____ Unexplained weight loss?: _____

Allergies: _____

Family history of speech/language difficulties?: _____

Please check all that apply:

Symptom	Never	Sometimes	Frequently
Difficulty Swallowing, gagging, choking/coughing while eating			
Picky eating/limited foods in diet			
Oral motor difficulties (weakness, incoordination)			
Snoring/restless sleep			
Limited vocabulary/verbal output			

Not being understood by others			
Difficulty understanding others/following directions			
Fluency (stuttering)			
Voice changes			
Pragmatic/social concerns			
Other:			

Please explain:

_____

_____

Impact on daily activities? (Social, school,etc.): _____

_____

School: _____ Grade: _____

Academic concerns?: _____

Previous evaluation or speech therapy? (where/when): _____

Was it helpful?: _____