Schie SPEECH

Speech Therapy Intake Form

Infant (0 to 6 months)

Patient Name: _____ **DOB:** _____

What is your name and relationship to the patient?

_____

Who is your support person and what is the relationship to the patient?

_____

Is this your first child? YES NO **If not, how many children do you have?** _____

Please describe any issues you are currently experiencing.

_____

_____

_____

_____

How does your problem impact your daily life?

_____

_____

_____

_____

Gestational and Birth History.
Please check all that apply to Mother's history:

- ☐ Infertility
- ☐ Miscarriages
- ☐ Abortions
- ☐ Invitro Fertilization (IVF)
- ☐ Breast Implants
- ☐ Sexual Abuse
- ☐ Breast Injury
- ☐ Cesarean Section
- ☐ Low Milk Supply
- ☐ Current Illicit Drug Use / Addiction
- ☐ History of Illicit Drug Use / Addiction
- ☐ Alcoholism
- ☐ Smoker
- ☐ Food Allergies: _____
- ☐ Gestational Diabetes
- ☐ Pre-Eclampsia
- ☐ Eclampsia
- ☐ Gestational Hypertension

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- ☐ Difficulty Breastfeeding
- ☐ Doula Support
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Bulimia
- ☐ None
- ☐ Vacuum-assisted Delivery
- ☐ Forceps-assisted Delivery
- ☐ HELLP Syndrome
- ☐ Anorexia
- ☐ STI / STD: _____
- ☐ Other : _____

Were there complications during pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Were there complications during delivery? ☐ Yes ☐ No

If yes, please explain: _____

Were there complications postpartum? ☐ Yes ☐ No

If yes, please explain: _____

Did you carry the baby to full-term? ☐ Yes ☐ No

If no, how far along were you at delivery: _____

Did the baby require any specialty care after delivery? ☐ Yes ☐ No

If so, what treatments: _____

APGAR score: _____

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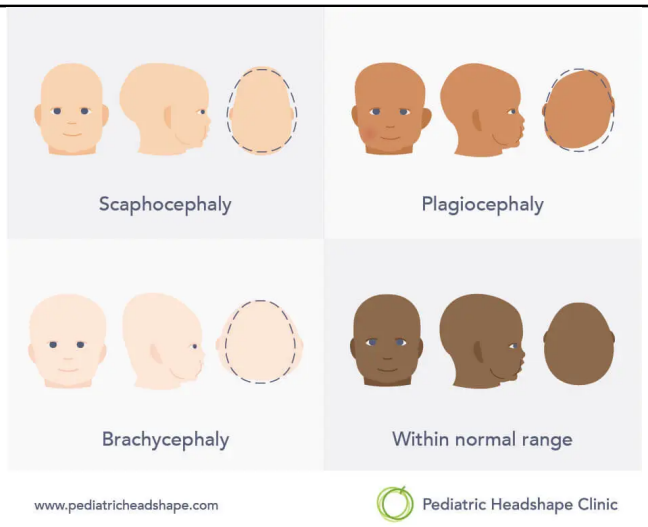
Infant Measurements

Birth weight:	
Birth length:	
Most recent weight:	
Date of most recent weight:	
Which head shape applies to your infant?	

Feeding History

How is your baby fed? Breast Bottle Both

What was your initial feeding plan? _____

What is your baby fed? Formula Breast Milk Both

If Formula, what brand / type: _____

If Breastmilk:

- ☐ Directly from Mother's breast
- ☐ Hand Expressed from Mother's breast
- ☐ Pumped from Mother's breast
- ☐ Donor breast milk

If you pump, which do you use:

- ☐ Manual / Hand Pump
- ☐ Single Electric Pump
- ☐ Double Electric Pump
- ☐ Hospital Grade Pump

If so…

How much milk are you producing? _____

How many feeds per day? _____

How many wet diapers per day? _____

How many poopy diapers per day? _____

Do you have any concerns about nutrition? YES NO

If yes, please list: _____

_____

_____

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Were you encouraged to see a specialist? YES NO

If yes, Referred by _____ to _____.

Did your child have any ties identified? YES NO If yes, by whom? _____

If yes, what is your plan?

- ☐ Exercise
- ☐ Release
- ☐ Not Sure

Did your child display the following while breast/bottle feeding? (Check all that apply)

- ☐ Difficulty Latching
- ☐ Reflux
- ☐ Coughing
- ☐ Noisy Breathing
- ☐ Gagging
- ☐ Crying
- ☐ Dribbling
- ☐ Clicking
- ☐ Chomping
- ☐ Sleepiness
- ☐ Changes in Breathing

Check all reponses your child has to foods and/or liquids:

- ☐ Coughing
- ☐ Vomiting
- ☐ Gagging
- ☐ Choking
- ☐ Food Refusal
- ☐ Wet Voice
- ☐ Sleepiness
- ☐ Breathing Changes
- ☐ Other: _____

Length of Feeds:

- ☐ 0 to 8 minutes
- ☐ 8 to 20 minutes
- ☐ 20 to 30 minutes
- ☐ 30 to 45 minutes
- ☐ 45 to 60 minutes
- ☐ Greater than 60 minutes
- ☐ Feeds every hour
- ☐ Feeds every 2-3 hours
- ☐ Feeds Randomly
- ☐ Neverending Feeds
- ☐ Other: _____

Which items has your child used?

- ☐ Breast
- ☐ Bottle
- ☐ Pacifier
- ☐ Sippy Cup
- ☐ Nipple Shield
- ☐ Teether
- ☐ Supplemental Nursing System
- ☐ Finger Feeder
- ☐ Infant Toothbrush
- ☐ Mesh Feeder
- ☐ Feeding Tube
- ☐ Syringe
- ☐ Open Cup
- ☐ Wide-base Bottle Nipple
- ☐ Narrow-base Bottle Nipple
- ☐ Slow Flow Nipple
- ☐ Standard Flow Nipple

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Communication History

Do you have any of the following concerns about speech production?

- ☐ No Cooing
- ☐ No Babbling
- ☐ Does not Respond to Sound
- ☐ Weak Cry
- ☐ Excessive Sleepiness
- ☐ Limited consonant sounds
- ☐ Imitates facial expressions
- ☐ Imitates Oral Motor Movements
- ☐ No Concerns
- ☐ Other: _____ _____ _____

Developmental History

Motor Skills (Check all that apply)

- ☐ Holds Head up
- ☐ Rolls Over
- ☐ Reaches for an object
- ☐ Turns head to the RIGHT
- ☐ Turns head to the LEFT
- ☐ Red Neck Creases
- ☐ Tolerates 30min of tummy time per day on a flat surface
- ☐ Tolerates 60min of tummy time per day on a flat surface
- ☐ Tolerates 90min of tummy time per day on a flat surface.
- ☐ Difficulty feeding on the RIGHT breast
- ☐ Difficulty feeding on the LEFT breast

Oral Motor Skills (Check all that apply)

- ☐ Sticks tongue out
- ☐ Moves tongue side to side
- ☐ Tongue rests on the roof of the mouth
- ☐ Tongue rests on the floor of the mouth
- ☐ Lips closed at rest
- ☐ Lips open at rest

Respiratory Skills (Check all that apply)

- ☐ Breathes from nose
- ☐ Breathes from mouth
- ☐ Breathes from mouth & nose
- ☐ Snores
- ☐ Noisy breathing when awake
- ☐ Noisy breathing when sleeping
- ☐ Lips turn blue or gray
- ☐ Needs supplemental oxygen
- ☐ History of using supplemental oxygen
- ☐ History of meconium aspiration

Communication Skills (Check all that apply)

- ☐ Coos
- ☐ Eye contact during feeds
- ☐ Eye contact during rest periods
- ☐ Good hunger cues
- ☐ Varies cries
- ☐ Needs to be woken up for feeds

Behavior History: Check all that apply

- ☐ Sensitive to Sounds
- ☐ Doesn't notice noises
- ☐ Noisy Breathing
- ☐ Easy to Soothe
- ☐ Hard to soothe
- ☐ Needs fast rocking
- ☐ Needs slow rocking
- ☐ Calmed by pacifier
- ☐ Unable to keep pacifier in mouth
- ☐ Does not use pacifier
- ☐ Cries at breast

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☐ Smiles ☐ Other: _____

<u>Education History</u>: (Check all that apply)

☐ Full Time Daycare ☐ Part Time Daycare ☐ N/A

Does anyone else in the family have a history of speech, language, hearing, learning, and/or feeling/swallowing problems? YES NO
If so, who and why? _____

Describe the primary caregivers' roles, level of education, occupation, and daily time spent during direct contact with the patient (% of day or description like "evenings & weekends").

Mother(s) _____

Father(s) _____

Other(s) _____

What are you hoping to accomplish with therapy? Check any that apply.

☐ Interpreting Baby's Cues
☐ Play & Interaction Training
☐ Attachment & Bonding Support
☐ Oral Exercise Program
☐ Tummy Time Program for head, neck, & shoulder development
☐ Breast Feeding
☐ Bottle Feeding
☐ Transition to Solids
☐ Tube weaning
☐ Tongue-Tie pre/post-op Program
☐ Collaboration with other providers

Other: _____
_____
_____