Schie SPEECH

# Speech Therapy Intake Form

Pediatric (6 months+)

**Patient Name:** _____ **DOB:** _____

**Feeding History**

Do you have any concerns about nutrition? YES NO

If yes, Please explain:_____

_____

Has your child ever had a swallow study (i.e., MBSS/VFSS, Esophagram, FEES, etc)? YES NO

Were you encouraged to see a specialist? YES NO

If yes, what specialty and whom? _____

Did your child have any ties identified? YES NO If yes, were they released? YES NO

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

- ☐ Difficulty Latching
- ☐ Coughing
- ☐ Crying
- ☐ Reflux
- ☐ Gagging
- ☐ Dribbling

What age did you introduce spoon feeding? _____

Did/Does your child have difficulties with SMOOTH pureed food?

☐ YES ☐ NO ☐ N/A

Did/Does your child have difficulties with CHUNKY pureed food?

☐ YES ☐ NO ☐ N/A

Did/Does your child have any difficulties with DISSOLVABLE SOLIDS (e.g. Puffs)?

☐ YES ☐ NO ☐ N/A

Did/Does your child have any difficulties with SOFT VEGGIES or FRUITS?

☐ YES ☐ NO ☐ N/A

Does your child have any of the following responses to food/liquids? (Check all that apply)

- ☐ Coughing
- ☐ Gagging
- ☐ Food Refusal
- ☐ Vomiting
- ☐ Choking
- ☐ Other:

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At what age did your child stop breast/bottle feeding? _____

Did your child have any difficulty transitioning to any of the following:

- ☐ Bottle
- ☐ Straw
- ☐ Cup
- ☐ N/A

Is your child on a restrictive or self-limiting diet? YES NO

Check all that apply:

- ☐ Finger Biting
- ☐ Object Chewing
- ☐ Extended Sippy Cup Use
- ☐ Takes Large Bites / Stuffs Mouth
- ☐ Eats less than 20 foods
- ☐ Nail Biting
- ☐ Clenches Teeth
- ☐ Low Appetite
- ☐ Chokes/Coughs while eating
- ☐ Hunger cues present
- ☐ Lip Biting
- ☐ Grinds Teeth
- ☐ Uses/Used Feeding Tube
- ☐ Burps Often
- ☐ Easily Calmed
- ☐ Lip Licking
- ☐ Excessive Drooling
- ☐ Noisy Eater
- ☐ Hiccups Often
- ☐ Difficult to Soothe
- ☐ Lip Sucking
- ☐ Extended Pacifier Use
- ☐ Messy Eater
- ☐ Eats Less than 10 foods
- ☐ Cries at Breast
- ☐ Cries at Table

Does your child have food aversions (e.g., taste, textures, temperature, color, size, etc)? YES NO N/A

If yes, please describe: _____

Length of Feeds

- ☐ Less than 30 min.
- ☐ Feeds every hour
- ☐ Feeds Randomly
- ☐ Greater than 30 min.
- ☐ Feeds every 2-3 hrs
- ☐ Other:

What would you prefer your child do?

- ☐ Graze all day
- ☐ Sit for a Meal
- ☐ No Preference

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Which items has your child used?

- ☐ Breast
- ☐ Bottle
- ☐ Pacifier
- ☐ Sippy Cup
- ☐ Straw
- ☐ Chopsticks
- ☐ Spoon
- ☐ Fork
- ☐ Knife

## Speech History

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

- ☐ No Cooing
- ☐ No Babbling
- ☐ No Response to sound
- ☐ No Concerns
- ☐ Other:

## Language Skills (Check all that apply)

- ☐ Babbles (baba)
- ☐ Jargon (long strings)
- ☐ Speaks meaningful words
- ☐ Combines Words (more ball)
- ☐ Understands most of what I say
- ☐ Understands some of what I say
- ☐ Communicates Verbally
- ☐ Communicates with pictures
- ☐ Communicates with gestures
- ☐ Coos
- ☐ Eye Contact
- ☐ Imitates Facial expressions
- ☐ Imitates Mouth Movements
- ☐ Able to express basic wants and needs
- ☐ Demonstrates Hunger Cues
- ☐ N/A

## Behavior History: Check all that apply

- ☐ Nervous
- ☐ Hyper
- ☐ Poor Concentration
- ☐ Sad
- ☐ Shy
- ☐ Destructive
- ☐ Easily Frustrated
- ☐ Self-Stimulation (rocking, flapping, etc.)
- ☐ Sensitive to Sounds
- ☐ Doesn't notice noises
- ☐ Likes Routine
- ☐ Prefers less structure
- ☐ Self injurious behavior
- ☐ Noisy Breathing
- ☐ Reduced Social Interactions
- ☐ Stridor
- ☐ Easy to Soothe
- ☐ Hard to Sooth
- ☐ Needs fast rocking
- ☐ Needs slow rocking
- ☐ Calmed by pacifier
- ☐ Unable to keep pacifier in mouth
- ☐ Does not use pacifier
- ☐ Curious

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- ☐ Dislikes Touch
- ☐ Cries at breast
- ☐ Flat Facial Expressions
- ☐ Reluctant
- ☐ Seeks Touch
- ☐ Smiles
- ☐ Independent
- ☐ Defiant
- ☐ Hyper Focused
- ☐ Empathetic
- ☐ Sympathetic
- ☐ Other:

**Education History: (Check all that apply)**

- ☐ Full-Time Daycare
- ☐ Part-Time Daycare
- ☐ Homeschool
- ☐ Full-Time PreSchool
- ☐ Part-Time PreSchool
- ☐ Private School Garde: _____
- ☐ Public School Grade: _____
- ☐ N/A

**Caregiver Report:**

What is your impression of your baby/child's social skills? _____

_____

What does your baby/child like? _____

**What are you hoping to gain from an evaluation or treatment? (Check all that apply)**

- ☐ Interpreting Baby's Cues
- ☐ Bottle Feeding
- ☐ Breast Feeding
- ☐ Transition to Solids
- ☐ Play & Interaction Training
- ☐ Tube weaning
- ☐ Understanding Skills
- ☐ Clear natural speech
- ☐ Oral Exercise Program
- ☐ Vocabulary skills
- ☐ Reduce Drooling
- ☐ Organizing Thoughts
- ☐ Tummy Time Program for head, neck, & shoulder development
- ☐ Behavioral Management / Following Routines
- ☐ Tongue Tie pre/post-op Program
- ☐ Building grammatically correct phrases
- ☐ Independence in daily living activities
- ☐ Eat a variety of foods
- ☐ Tooth Brushing
- ☐ Chewing Skills

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Does anyone else in the family have a history of speech, language, hearing, learning, and/or feeding/swallowing problems? YES NO

If yes, Please describe: _____

Describe the primary caregivers' roles, level of education, occupation, and daily time spent during direct contact with the patient.

Mother(s) _____

Father(s) _____

Other(s) _____