"where children discover what is possible"

17620-A Redland Road
Rockville, Maryland 20855
301-869-7505

INTAKE FORM: Myofunctional, Feeding, and Articulation

Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parents' Names: _____

Primary Address: _____

_____

Contact Telephone Numbers and Email Addresses

Mother's contact: (H)_____ (C) _____

Mother's email: _____

Father's contact: (H)_____(C)_____

Father's email: _____

INSURANCE INFORMATION

Insurance Company _____

Name on policy _____

Insured's ID number _____ Group Number _____

Insured's Date of Birth_____

Insured's Employer:_____

Relation of client to insured:_____

Mother's Employer: _____

Address: _____

Work Phone: _____ Work email:_____

Father's Employer: _____

Address :_____

Work Phone: _____ Work email: _____

Age of Siblings: Brothers:_____

Sisters:_____

School Attending:_____

Grade:_____

Does your child currently receive school based therapy services?_____

If yes, what type and how often:_____

_____

The Pediatric Development Center believes that collaboration with all members of your child's developmental and medical team enhances our ability to deliver the best quality of care. Please provide the name and address of all professionals you would like for us to collaborate. By signing below you are giving PDC permission to send initial reports, periodic progress updates, and/or speak with the team members. **My child is treated by the following medical professionals:**

___Pediatrician: _____

___Developmental Pediatrician: _____

___Psychologist: _____

___Neurologist: _____

___Occupational Therapist: _____

___Speech Therapist: _____

___Physical Therapist: _____

___Behavior Specialist: _____

___Gastroenterologist:_____

___ENT:_____

Other: _____

I was referred to PDC by:_____

_____ _____

Signature Date

QUESTIONNAIRE

1. What specific behaviors or skill deficits demonstrated by your child prompted you to seek a speech/occupational therapy evaluation?

2. Did any other professional recommend a speech/occupational therapy evaluation (teacher, psychologist, doctor, etc) for your child? If yes, whom?

3. Please list specific skills or changes in behavior you would like to see your child gain through speech/occupational therapy treatment?

4. My child's most significant areas of need are: (circle all that apply)

language	articulation	feeding	reading/writing process
attention	handwriting	social skills	sensory processing
anxiety	body awareness	self-regulation	medical

5. Please list past therapy experience including treatment programs and dates.

6. Please describe your child's school and/or social experience.

7. What do you feel will help your child succeed academically and socially?

BIRTH HISTORY:

LENGTH OF PREGNANCY: _____ weeks. Did you smoke cigarettes, drink alcoholic beverages, take medication or use drugs during your pregnancy?

Were there any complications during pregnancy? If so, please explain.

Were there any problems during labor and delivery? Please explain. Vaginal or Caesarian

What was the child's weight and general condition at birth?

MEDICAL HISTORY

List all significant medical diagnoses, treatments, and physician information that may be relevant to your child's visit today. Please provide dates of diagnosis and treatment (ex: chronic ear infections, PE tubes, Down Syndrome, concussion, Autism, etc...)

Has your child been hospitalized? If so, include age, reason, and length of stay:

History of illness, include age:

Does your child have frequent colds or running/stuffed nose? Yes No

List any known allergies your child has and associated treatments.

My child's overall health is _____.

Is your child currently under a doctor's care? Is s/he taking any medications? If so, what kind and why?

Does your child have a history of middle ear infections? If so, include when and how often. Has he/she required ear surgery?

Date and result of last hearing test:_____

Where was your child's hearing tested?_____

Does your child wear hearing aids?_____

Date and result of last vision test. _____Glasses?_____

Describe achievement of developmental milestones including gross and fine motor, communication, articulation, and feeding skills.

ORAL/FEEDING HABITS AND SENSORY INFORMATION

Has your child had any feeding difficulties? (e.g.: drooling, swallowing)

Does s/he avoid any foods? If so, please describe food preferences and meal times.

When did your child wean from the breast or bottle?

Did you child us a sippy cup for more than 3-6 months? Yes No
Does your child use a straw to drink liquids? Yes No

When did your child stop sucking his/her thumb or fingers? _____

Did your child use a pacifier? If so, for how long?

Does your child grind his teeth and/or tense his jaw?

Does you child exhibit open mouth posture and mouth breathing? Yes No

Is your child sensitive to textures? Yes No

Is your child sensitive to sound? Yes No

Is your child sensitive to smell? Yes No

Is your child sensitive to touch? Yes No

Does your child exhibit any self-stimulatory behavior? Please describe.

Which hand does your child use primarily?

Does your child seem to have any balance or coordination difficulties? If so, please describe.

How are your child's sleeping patterns?

How does your child currently communicate his/her wants and needs?

How clear is your child's speech?

How well does your child understand what is being said to him/her?

SOCIAL HISTORY

How would you describe your child's personality?

Describe your child's socialization skills with family and familiar people.

How does your child react to unfamiliar people and/or situations?

How does your child interact with other clinicians?

What are your favorite activities/hobbies?

Describe your child's activity level.

ADDITIONAL INFORMATION

Is there any other information about your child that would be helpful to us in evaluating your child? Please explain.

Young Children: Please list the name brand of your child's utensils, cups, straws, and/or bottles that are being used at this time.

Young Children: Please describe how your child is positioned during feedings, include where the child sits, what is happening around the child, and how long it takes the child to eat.

Older Children/Adolescents: Are your currently under the care of an orthodontist. If so, please provide the doctor's name, phone number and permission to collaborate.

The Pediatric Development Center provides treatments to enhance and develop speech, language, feeding, reading/writing, fine motor, and sensory skills. Often times, children's needs bridge the professional boundaries of occupational therapy and speech therapy and children may benefit from receiving both speech and OT. Please check the statements below that apply.

_____ My child is here today for a consultation with an occupational therapist, but I am interested in learning more about speech therapy. Please have the speech therapist contact me.

_____ My child is here today for a consultation with a speech therapist, but I am interested in learning more about occupational therapy. Please have the occupational therapist contact me.

_____ I am interested in learning more about social language groups.

_____ I am interested in learning more about FastForWord.

_____ I am interested in learning more about Interactive Metronome.

_____ I am interested in music therapy.

_____ I am interested in art therapy.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received a copy of *The Pediatric Development Center's Privacy Practice Policy.*

Client's name: _____ DOB: _____

Guardian's name: _____ (printed)

Relationship to patient: _____

Guardian's Signature: _____

Date: _____

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/ clinical information on your answering machine, if available?

☐ YES ☐ NO

OFFICE USE

Witness: _____ Date: _____

Comments/Restrictions: _____

_____

_____

_____