Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

PATIENT REGISTRATION FORM – SPEECH LANGUAGE THERAPY

PATIENT NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER	SEX
ADDRESS: NUMBER & STREET	APT#	CITY STATE	ZIP CODE
HOME PHONE		EMAIL ADDRESS	
REFERRED BY		PHYSICIAN PHONE NUMBER	
PEDIATRICIAN/PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE NUMBER	

MOTHER/GUARDIAN NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER	
ADDRESS: NUMBER & STREET	APT#	CITY STATE	ZIP CODE
HOME/CELL PHONE		EMAIL ADDRESS	
FATHER/GUARDIAN NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER	
ADDRESS: NUMBER & STREET	APT#	CITY STATE	ZIP CODE
HOME/CELL PHONE		EMAIL ADDRESS	

PRIMARY INSURANCE	POLICYHOLDER'S NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	
SECONDARY INSURANCE	POLICYHOLDER'S NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	

I am an authorized beneficiary of the above insurance plan(s). I confirm that all of the above information is accurate and I agree to notify Pediatric Therapy Links, LLC of any changes.

______________________________	______________	______________
Parent/ Guardian Signature	Date	Relationship to Patient

Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990
Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ______________________________________ **Patient DOB:** __________________

CURRENT CONCERNS:

1. Reason for today's visit: Speech (Please describe)____
   ____
   Language (Please describe) ____
   ____
   Feeding (Please describe) ____
   ____

2. Has your child had any speech language evaluations within the past six months? If so, with what provider, what assessments were administered, and when was this assessment completed with your child?
   ____
   ____

3. When did you first notice a concern with your child's speech and language development?
   ____

4. Has your child had a hearing test within the past year? ____

FAMILY BACKGROUND

1. What is the primary language spoken in the home?
   English Spanish
   Creole

2. What is your child's dominant language?
   English Spanish
   Creole

3. Please list any other children in the home.
   _____________________ (Age) _____ _____________________ (Age) ____
   _____________________ (Age) _____ _____________________ (Age) ____

4. Are there any family members or relatives who have or have had the same problem?
   No Yes If yes, who and please describe ____
   ____

Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ____ **Patient DOB:** ___________________

BIRTH HISTORY

1. Were there any illnesses or complications during pregnancy with this child?
   No Yes If yes, please explain? ____
   ____

2. Pregnancy term and birth weight: Full Term If no, how many weeks? _______ Birth Weight ____

3. Delivery Method: Via Cesarean Section Vaginal Breach

4. Were there any drugs or medications taken during this pregnancy?

   No Yes If yes, please explain? ____

5. Were there any immediate problems following the birth or during the first 2 weeks of the infants life?
   No Jaundice Feeding Required Oxygen Sucking or swallowing problems
   Sleep Patterns Infant required a NICU stay (If so, how long and why?)____

6. Develpmental Milestones:
   Babble/ Coo age __________
   Say first word age __________
   Put 2-3 words together age __________
   Speak in sentences age __________
   Sit alone age __________
   Crawl age __________
   Walk age __________

MEDICAL HISTORY:

1. How is your child's overall health? Good Fair Poor

2. Are immunizations up to date? Yes No

3. Does your child have any known allergies? None Yes If yes, please list: _____________________
   ____

4. List all medications and dosages currently prescribed to your child:

Medication	Dosage	Purpose

Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ____ **Patient DOB:** __________________

5. Does your child have a history of surgery or hospitalizations?
   No Yes (please explain) ____
   ____

6. Please check the following as they apply to your child:
   Austim/ PDD Down Syndrome Cerebral Palsy ADHD/ADD
   Dyslexia Hearing Loss Cognitive Impairment
   Psychological/ Behavioral Concerns None

7. Has your child had any of the following conditions?
   Asthma Low Birth weight Cleft Lip Cleft Palate
   Seizure Food Sensitivities Spinal Cord Injury Head Injury
   Adenoidectomy Tonsilitis Visual Impairments Hearing Impairments

8. Please describe any other relevant medical diagnoses: ______________________________________
   ____

9. Does your child have a history of ear infections? No Yes
   If yes, are PE Tubes in place? No Yes, if yes when and are they still intact?____________________

SPEECH LANGUAGE CONCERNS:

1. Please indicate any/ all areas of concern:

   Pronouncing a variety of sounds
   Describing Events
   Understanding Directions
   Recognizing Familiar Objects
   Using Words to Communicate Consistently
   Answering Questions
   Speaking Fluently
   My Child's Vocal Quality (hoarseness of voice)

2. Which of the following best describes your child? (Select all that apply)
   Does not Use Words
   Gestures More than Using Words
   Easy to Understand
   Difficult for my Family to Understand
   Difficult for others to Understand
   My Child's Speech is not Fluent
   My Child's Voice Sounds Hoarse Most of the Time

Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ____ **Patient DOB:** __________________

3. Does your child: (Please check all that apply)
   - Repeat Sounds, words, or Phrases Over and Over
   - Needs Directions repeated frequently
   - Does Not Play Appropriately with Toys
   - Plays Repeatedly with the Same Toys or Watches the Same Shows Over and Over Again
   - Engages in Meaningful Conversations with Others

4. Does your child engage in eye contact during conversations?
   - Yes
   - Sometimes
   - No

5. How does your child communicate his/ her wants and needs?
   - Looking at Objects
   - Sounds/ Grunting
   - Pointing/ Gesturing
   - Single Words
   - 2-4 Word Phrases
   - Complete Sentences
   - Conversations
   - Picture Symbols/ PECS
   - Sign Language

6. Estimate how many words are in your child's vocabulary (words they regularly say on a daily or weekly basis):
   Receptive (words my child understands) _________ Expressive (words my child says) _________

7. Does your child demonstrate frustration when he/ she is not understood by others?
   No Yes

FEEDING CONCERNS:

1. How would you characterize your child's diet?

   - Regular all foods allowed: no known food allergies or dietary restrictions.
   - Regular with exceptions: List food allergies/ dietary restrictions: _________________________________

   ____
   - Pureed (requiring very little chewing ability)
   - Mechanical Soft (requiring some chewing)
   - Advanced (soft foods that require more chewing ability)

Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

Patient Name: ____ **Patient DOB:** ___________________

2. Has your child had a Modified Barium Swallow Study? If so, when and where was this completed? Please also indicate the outcome of this study and provide our office with a copy of the report if you have a copy.
   ____
   ____

3. Has your child participated in Feeding Therapy in the past?
   No Yes

4. Would you describe your child as a "picky eater"?
   No Yes

EDUCATIONAL BACKGROUND:

1. Please indicate the following:
   Name of your child's School:_____________________________________ Grade: __________
   Any grades repeated: ________________ Type of Classroom: General Education ESE

2. Does your child have an IEP? No Yes, Program: ________________________________

3. Please indicate any/ all areas of difficulty: Reading Writing Math Spelling Interacting

BEHAVIORAL BACKGROUND:

Please check all that apply:

Behavior	Yes	No	Behavior	Yes	No
Friendly/ Outgoing			Mostly Quiet		
Is Usually Happy			Poor Memory		
Is impulsive/ restless			Poor turn taking		
Sleeping Difficulties			Difficulty concentrating		
Attentive			Lacks pretend play		
Cooperative			Avoids group play		
Eating Difficulties			Avoids eye contact		
Withdrawn			Recognized danger		
Destructive/ Aggressive			Overly Active		
Imitated actions/ speech			Plays with toys appropriately		
Difficulty separating			Difficulty with transitions		
Understands praise			Follows familiar commands		