BRONSON

Patient Name _____ Date of Birth _____

Please complete this form before you see the therapist. This information will help the therapy team to better understand your child's current conditions to work together to best meet your child's needs.

Parent/Guardian's Name_____

Child's Main Doctor:_____Phone_____

The following people have my consent to pick up the therapy schedule or accept phone calls regarding my child's schedule:_____

Do we need to work out therapy schedules with other people? □ No □ Yes
If yes, who? _____

What are the problems that bring your child to therapy today?_____

_____

_____

What are your goals for your child's therapy?_____

Medical History

Birth History: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Breech ☐ Induced ☐ Full Term ☐ NICU Stay

☐ Multiple Birth ☐ Premature: How early? _____ Birth Weight _____

Complications of pregnancy/delivery: _____ _____

Has your child ever had surgery? ☐ No ☐ Yes Dates: __

What is the primary language spoken in your home? _☐ English ☐ Other (specify)_____
_____

Has your child ever stayed in the hospital? ☐ No ☐ Yes If yes, what for? _____

_____

Does your child have any allergies: ☐ No ☐ Yes If yes, please list (include reaction):

_____

_____

What test(s) has your child had?

☐ MRI ☐ CT ☐ X-Rays ☐ Head Ultrasound ☐ Upper GI ☐ EEG
☐ Swallow Study/Flexible Endoscopic Evaluation of Swallowing ☐ Nasal Endoscope
☐ Blood work/Labs ☐ Lower GI ☐ Milk Scan ☐ PH Probe
☐ Hearing Test

Other tests?_____

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List medicines your child is taking:_____

_____

Please check any items related to your child's medical history:

☐ Asthma	☐ Chronic ear infections	☐ Balance problem	☐ Cleft palate
☐ Brain injury	☐ Coordination problem	☐ Broken bone	☐ Cranial bleeding
☐ Cancer	☐ Diabetes	☐ Cerebral palsy	☐ Developmental delay
☐ Stroke	☐Feeding problems	☐ Sleep disorder	☐Heart/cardiac problems
☐ Speech delay	☐High/low blood pressure	☐Muscle tightness	☐ Reflux
☐Seizures	☐Shunt/hydrocephalus	☐ Bronchitis, pneumonia, or chronic respiratory infections	

Has your child ever been evaluated by:

☐ Audiologist	☐ Neurologist	☐ Physical Therapist
☐ Ear, nose, throat (ENT) specialist		☐ Nutritionist
☐ Gastroenterologist	☐ Occupational Therapist	☐ Speech Therapist
☐ Genetic specialist	☐Psychiatrist	☐ Social Worker
☐ Other Specialist		

Social History

What is the primary language spoken in the home? _____

Does your child attend daycare? If yes, how often?_____

Is your child in the Early On program, or a school or community based therapy program(s)?

☐ No ☐ Yes If yes, please list: _____

_____

_____

Developmental History: Please list the age when your child first:

Rolled: _____	Held bottle: _____	Smiled: _____
Sat: _____	Used spoon: _____	Babbled: _____
Walked: _____	Used cup:_____	Crawled: _____
Reached for toy:_____	Ate solid food:_____	

What does your child have trouble with?

☐ Paying attention	☐ Sitting	☐ Rolling	☐ Standing
☐ Walking	☐ Crawling	☐ Picking things up	☐ Talking
☐ Eating	☐ Dressing	☐ Endurance	☐ Jumping
☐ Sleeping	☐ Swallowing	☐ School	☐ Memory
☐ Playing with others			

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Does your child?

☐ Avoid certain textures of food
☐ Frequently bump/push into others
☐ Avoid walking barefoot
☐ Dislike hair being cut
☐ Have trouble calming self
☐ Avoid getting messy
☐ Dislike loud sounds
☐ Dislike spinning/swinging
☐ Dislike face being washed
☐ Wake up with pain
☐ Dislike bright lights
☐ Like spinning/swinging
☐ Dislike teeth being brushed
☐ Dislike being hugged or cuddled

Speech and Language Development

Please check any items that apply to your child's speech behavior:

☐ Does not speak clearly
☐ Has trouble understanding questions
☐ Has trouble remembering
☐ Throws tantrums
☐ Has trouble relating to others
☐ Seems to be aware of the problems
☐ Shows anger about speech problems
☐ Does not follow directions
☐ Has trouble sitting still
☐ Has trouble using right words
☐ Has trouble with behavior
☐ Seems uncoordinated
☐ Has trouble in school because of speech

How does your child usually communicate? (Check all that apply)

☐ Eye contact
☐ Pointing
☐ Sounds
☐ Pushing/pulling
☐ Gestures
☐ Single words
☐ Babbling
☐ Short phrases
☐ Other (Describe):_____

Is your child able to understand? (Check as many as possible)

☐ Gestures
☐ Sentences
☐ Words
☐ Short phrases

Do gestures have to be used for your child to understand words, short phrases or sentences?

☐ No ☐ Yes ☐ Sometimes

What age did your child say his/her first word? _____ Put two words together? _____

What age did sentences start? _____ Were they clear? _____

How old was your child when you first became concerned? _____

Who was first to become concerned? _____

Do you (child) feel safe at home? ☐ No ☐ Yes

Is your child at risk to be physically or sexually hurt? ☐ No ☐ Yes

Do you (child) feel adequately cared for? ☐ No ☐ Yes

General Comments:

_____

_____ _____

Signature of Parent/Guardian Date

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Therapist Use Only

Interdisciplinary Communication:

☐ SLP: _____

_____

_____

☐ OT: _____

_____

_____

☐ PT: _____

_____

_____

Reviewed by: ☐ SLP Signature _____ Date: _____

☐ OT Signature _____ Date: _____

☐ PT Signature _____ Date: _____

Copy to: ☐ OT
☐ PT
☐ SLP

Feeding Addendum

_____
Patient Name Date of Birth

Are you or your doctor worried about your child's growth? ☐ No ☐ Yes
Current weight_____ Percentile _____
Current height _____ Percentile _____
Head circumference _____ Percentile_____

Has your child (had):

☐ Constipation
☐ Frequent drooling
☐ Enlarged tonsils/adenoids
☐ Frequent gagging
☐ Ear tubes placed
☐ Ear infections
☐ Problems swallowing
☐ A feeding tube
☐ Frequent hoarse voice
☐ Frequent frustration
☐ Pain related to eating
☐ Tonsils/adenoids removed
☐ Treatment for reflux
☐ Vomiting
☐ Trouble staying asleep at night
☐ Frequent spit ups
☐ Stopped breathing (apnea)

How often and when do vomiting, spitting up and/or gagging happen?

_____

Past and Current Mealtime Information:

Describe your child's early feeding history:

☐ Breast-fed

What ages?_____ __ Problem(s)?_____

How long did they nurse? _____

☐ Bottle-fed

What ages?_____ Problem(s)?_____

How much did they eat? _____

What age did you begin baby foods? (Stage 1, 2 and 3 food types)? _____

How did your child do with switching to baby foods?_____

Current Feeding Routine:

How often does your child eat and drink? What are his/her usual mealtimes and snack times?

What foods/liquids does your child prefer to eat?

for breakfast?_____

for lunch?_____

for dinner?_____

for snacks?_____

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What do you feed your child? (check all that apply):

☐ Regular liquid	☐Thick liquid	☐ Prepared in blender
☐ Stage 1 or 2 food types	☐ Stage 3 food types	☐ Mashed table foods
☐ Soft table foods	☐ Hard table foods	☐ Foods such as Infant Puffs that melt in your mouth

☐ Other: _____

Which of these foods is easiest for your child to eat? _____

Which of these foods is hardest for your child to eat?_____

Who usually feeds your child?_____

Where is your child fed?_____

What is the average time it takes to feed your child? _____

Other information you would like us to have? _____