Serenity Pediatric Therapies
SPEECH, LANGUAGE, FEEDING, & SWALLOWING

2023 Child **Intake** Packet/History

Today's Date: _____

Patient/Caregiver Information:

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male Female

Diagnoses (if known):

_____

_____

Parent(s) / Guardians: _____

Street Address: _____

City, State, Zip: _____

Phone #1: _____ Cell Home Work Other

Phone #2: _____ Cell Home Work Other

Email #1: _____ Email #2: _____

How did you hear about us: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Primary Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved in Care:

Referring Physician (if different than Primary): _____

Phone Number: _____

Physician Address: _____

Other Physicians and Specialists:

_____

_____

Name of Insurance Company: (If Medicaid, you only need to add the Member ID and Branch of Medicaid)

_____

Insurance Phone # _____

Member ID # including alpha prefix if applicable: _____

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Group #: _____
Primary Insured Name (if applicable): _____
Primary Insured Date of Birth (if applicable): _____
Primary Insured Address (if different than the patient)
_____
Relationship to patient (Check one): Self_____ Spouse_____ Child____ Other_____

Family Background:

Parent 1 Name: _____ Parent 2 Name: _____
Age: _____ Age: _____
Occupation: _____ Occupation: _____
Marital Status: Single Married Separated Divorced

What adults does the child live with? Circle all that apply:
Birth Parent(s) Adoptive Parent(s) Foster Parent(s) Grandparent(s) Both Parents Parent 1 Only Parent 2 Only
Other:

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____ Age: _____ M F Health: _____
Child 2 Name: _____ Age: _____ M F Health: _____
Child 3 Name: _____ Age: _____ M F Health: _____
Child 4 Name: _____ Age: _____ M F Health: _____

Is there anything additional you would like to share about the family / home environment?
_____

Medical History:

Describe any pertinent information about your child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____

Mother's Health During Pregnancy:

Were there any infections or illnesses prenatally or during labor? Yes No If yes, please describe:
_____
What was the mother's age at the time of delivery? _____ years
Were there any complications for mom during labor or delivery? Yes No
If yes, describe:
_____
_____

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Child's Health:

How many weeks gestation was the child when born? _____ weeks (40 weeks is typical)

The child was _____ lbs ____oz

How was the child delivered? Vaginally Cesarean Section

Were there any complications for your child during labor or delivery? Yes No If yes, describe:

_____

Indicate and describe all that apply:

Tonsillectomy	Yes No
Adenoidectomy	Yes No
Asthma or other breathing problems	Yes No
Behavior Issues	Yes No
Cardiac Issues	Yes No
Ear Infections	Yes No
Tubes in ears	Yes No
Hearing loss	Yes No
Encephalitis	Yes No
Meningitis	Yes No
Mumps	Yes No
Seizures	Yes No
Sensory Issues	Yes No
Sleep Issues	Yes No
Tongue Tie	Yes No
Traumatic Brain Injury	Yes No
Vision Issues	Yes No

If yes to any of the above, please describe in further detail:

_____

_____

_____

Has your child had any surgeries or ever been hospitalized? Yes No

If yes, please list when and why:

_____

_____

Is your child currently on any medications? Yes No

If yes, please list the medications, the dosage, and what the medicine is for:

_____

_____

_____

Does your child have any known allergies? Yes No
If yes, please list allergens:
_____

Does your child use any equipment such as a communication device, walker, wheelchair, etc.? Yes No
If yes, please list and/or describe:
_____

Have you had your child's hearing checked? Yes No
If yes, when and the result:
_____

Have you had your child's vision checked? Yes No
If yes, when and the result:
_____

Feeding History

Does your child do any of the following:

Choke on liquids	Choke on foods
Avoid foods	Maintain a special diet whether it be food or liquid
Use a pacifier	Suck thumb

Please describe any of the above that was indicated:
_____
_____
_____