Serenity Pediatric Therapies
SPEECH, LANGUAGE, FEEDING, & SWALLOWING

2025 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:
____
____
____