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Pediatric Speech/Myofunctional Intake

Child's Name: _____Date of Birth: _____
Parent's Name (s): _____Phone: _____
Home Address: _____
Email address: _____
Child's school: _____Grade: _____

Referred by?

First Name: _____ Last Name: _____

Phone: _____

Pediatrician

First Name: _____ Last Name: _____

Phone: _____

Dentist

First Name: _____ Last Name: _____

Phone: _____

Orthodontist

First Name: _____ Last Name: _____

Phone: _____

REASON FOR REFERRAL:

What are your main concerns about your child's speech/myofunctional skills?

_____

When did you first become concerned with your child's speech/myofunctional skills?

Motor Development

Approximately what age did your child reach the following motor milestones:

Roll over _____ Sit alone ____ Crawl _____ Walk _____

Speech and Language Development

Approximately what age did your child reach the following speech milestones:

_____Babble ____Say his/her first word (s)
_____Put two words together ____Speak in short sentences

Has your child ever received a speech/language evaluation?
Yes_____No_____Date: _____

Has your child received speech/language therapy previously?
Yes____ No____ If yes, when and for how long? _____

Is your child's speech difficult to understand? Yes/No
If yes, please describe:

_____

If your child aware of, or frustrated by, any speech difficulties? Yes/No
Is your child reading? Yes____ No____ Emerging____

If no or emerging, please describe your child's reading / writing skill level:

_____

MEDICAL HISTORY:

Were there any problems during your pregnancy? Yes / No

Were there any problems during your child's birth? Yes / No

Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes / No

If yes to any of the above, please describe: _____
_____

List any medications currently being taken: _____

Does your child have any allergies (medicine, food, environment)? Yes / No

If yes, please list: _____

Has your child been evaluated by an ear, nose, and throat (ENT) doctor? Yes / No
If yes, why: _____

Hearing

Does your child have a history of frequent ear infections? Yes / No If yes, please describe:
_____

Does your child have ear (PE) tubes? Yes / No, If yes, what date? _____

Has your child's hearing been tested? Yes / No

If yes, when: _____ where (school, clinic, etc.): _____

Results: _____

Sleep

Does your child have any sleeping difficulties? _____

Does your child snore? _____

Does your child tend to breathe through the mouth during the day? Yes/No

Does your child have a dry mouth on waking up in the morning? Yes/No

Does your child occasionally wet the bed? Yes/No

Does your child appear tired during the day? Yes/No

Feeding/Eating History: check all that apply (past and present behaviors)

____Thumb/finger sucking
____Pacifier use
____Early feeding difficulty
____Pain when nursing for mother
____History of thrush
____Any drooling
____Difficulty swallowing pills
____Choking
____Takes a long time to eat
____Tongue Thrust
____Tongue Tie
____Bottle or Breastfed: How long? _____
____Doesn't like his/her teeth brushed

____Teeth clenching/grinding (circle)
____Sensitive gag reflex
____Excessive drinking while eating
____Weight gain issues
____Reflux / Colic
____Mouth breathing
____Noticeable difficulty chewing or swallowing
____Messy eater / Noisy eater (circle)
____Pulls lips in to clean them (not lick)
____Bites rather than licks ice cream

If you checked off any of the above, please describe the problem in greater de©tail:
_____
_____
_____

Who should we thank for referring you? _____

Please return this form to dinaezslp@gmail.com
If you have a current speech evaluation or other pertinent test results, please forward them to the above email address.

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