BRONSON	Affix Patient Label
	Patient Name: DOB:

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? ☐ Yes ☐ No

If yes, who? _____

What date did these problems start? _____

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

_____

_____

What are your (or your child's) goals for therapy? _____

Has your child had past treatment for this problem or similar problems? ☐ Yes ☐ No

If yes, what kind: ☐ Surgery ☐ Physical Therapy ☐ Occupational 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: _____

Please list any surgeries, fractures, dislocations or hospitalizations with dates: _____

_____

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

_____

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

_____

_____

What test(s) has your child had?

☐ CT ☐ MRI ☐ 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? _____

List medicines your child is taking: _____

_____

BRONSON

Affix Patient Label

Patient Name: DOB:

Please check any items related to medical history:

- ☐ Asthma
- ☐ Balance problem
- ☐ Brain Injury
- ☐ Broken bone
- ☐ Bronchitis, pneumonia, or chronic respiratory
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic ear infections
- ☐ Cleft Palate problems
- ☐ Coordination problem
- ☐ Cranial bleeding
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Feeding problems
- ☐ Heart/Cardiac problems
- ☐ High/low blood pressure
- ☐ Muscle tightness
- ☐ Reflux
- ☐ Seizures
- ☐ Shunt/Hydrocephalus
- ☐ Sleeping disorder
- ☐ Speech Delay
- ☐ Stroke

Has your child ever been evaluated by:

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

Check all your child uses:

☐ Tobacco: Number per day _____ ☐ Caffeine (coffee/soda): Number of caffeinated cups per day _____

☐ Alcohol: Number of alcoholic drinks per day _____

Social History

What is the primary language spoken in the home? _____

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

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

☐ Yes ☐ No 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?

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

Does your child:

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

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
- ☐ Having 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 all that apply)

- ☐ Gestures
- ☐ Sentences
- ☐ Words
- ☐ Short phrases

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

- ☐ Yes
- ☐ No
- ☐ Sometimes

When did your child say his/her first word?_____Put two words together?_____

When did sentences start?_____Were they clear?_____

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

Who was first to become concerned?_____

Do you have concerns about your child's hearing? ☐ Yes ☐ No

In the past month has your child used home health services? ☐ Yes ☐ No

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

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

General Comments:

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

Therapist Use Only

Interdisciplinary Communication:

☐ SLP: _____

_____

_____

☐ OT: _____

_____

_____

☐ PT: _____

_____

_____

Reviewed by: ☐ SLP Signature _____ Date: _____

☐ OT Signature _____ Date: _____

☐ PT Signature _____ Date: _____

Copy To: ☐ OT
☐ PT
☐ SLP

BRONSON	Affix Patient Label
	Patient Name: DOB:

Feeding Addendum

Are you or your doctor worried about your child's growth? ☐ Yes ☐ No

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 long 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?_____

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? _____