Patient Intake Form
Pediatric Feeding

Date: _____

Patient Name: _____ Date of Birth: _____

Parent / Guardian Names: _____

Address: _____
Street Address City State Zip

Phone #s: _____ _____
(Parent/guardian 1 home) (Parent/guardian 1 cell / work)

_____ _____
(Parent/guardian 2 home) (Parent/guardian 2 cell / work)

Email(s):_____

How did you hear about Arise Therapies, LLC? _____

Primary Care Provider (name and #): _____
Referred by PCP? ❑ Yes ❑ No

Other physicians: _____

Primary insurance company: _____ ID #: _____

Primary insured name: _____ Relationship to patient: _____

Secondary insurance company: _____ ID #: _____

Secondary insured name: _____ Relationship to patient: _____

Number of siblings and ages: _____

School name: _____ Grade: _____

Has IEP? ❑ Yes ❑ No School SLP (name and #): _____

Recent hearing screening / test? ❑ Yes ❑ No ❑ Pass ❑ Fail

Any current concerns regarding hearing? _____

Primary concerns today: _____

_____

_____

_____

_____

(For office use only)
Date of evaluation: _____ *Diagnosis:* _____ *ICD10:* _____

Birth History

Born full term? ❑ Yes ❑ No If no, how many weeks? _____ Birth weight: _____

Please describe if any complications related to the pregnancy / birth: _____

_____

Developmental History

Please list the approximate age at which your child achieved the following developmental milestones:

Babbled: _____ Said first words: _____ Combined two words: _____

Walked: _____ Toilet trained: _____ Started solid foods: _____

Weaned from bottle/breast: _____ Self-fed with spoon: _____

Breast fed? ❑ Yes ❑ No Bottle fed? ❑ Yes ❑ No Use a pacifier? ❑ Yes ❑ No

What percent of the time is your child understood by family? ____% By an unfamiliar listener? ____%

Has your child received any other evaluation or therapy (ST, OT, PT, vision, counseling, etc)? ❑ Yes ❑ No
Please briefly describe, including when and where:

Past services: _____

Current services: _____

Current Symptoms

Check any problems you are currently experiencing: (If a choice is provided, circle the appropriate answer).

- ❑ Picky eater
- ❑ Drooling during non-mealtimes
- ❑ Losing food or liquid or both from mouth during meals
- ❑ Difficulty drinking with a straw
- ❑ Difficulty chewing
- ❑ Difficulty moving food or liquid or both out of the mouth and into the throat
- ❑ Difficulty getting the swallow started
- ❑ Pain during swallow
- ❑ Food or liquid or both coming out of the nose
- ❑ Coughing or choking with food or liquid or both
- ❑ Sneezing during meals
- ❑ Eyes watering or nose running during meals
- ❑ Sensation of food sticking in the throat or chest – where specifically? _____
- ❑ Needing to avoid certain food or liquid or both
- ❑ Regurgitation or being unable to keep food or liquid or both down
- ❑ Burping during or after or both meals
- ❑ Coughing or choking on saliva during non-mealtimes
- ❑ Waking at night coughing or choking
- ❑ Thickened/excess mucus or secretions
- ❑ Ulcers or sores in mouth

❑ Decreased mouth/jaw opening
❑ Other: _____

Current Diet: ❑ Nothing by mouth (PEG/N-G tube/TPN) ❑ Oral intake
Solids: ❑ Regular ❑ Soft ❑ Pureed
Liquids: ❑ Thin or regular ❑ Nectar-thick ❑ Honey-thick
Do you avoid certain foods because of swallowing difficulties? ❑ Yes ❑ No
Explain: _____

Please list your child's favorite foods:

_____

_____

Please list your foods your child avoids:

_____

_____

Medical History

Has your child had any of the following?

❑ Adenoidectomy	❑ Esophageal disorders	❑ Seizures
❑ Allergies	❑ Ear infections	❑ Sleeping difficulties
❑ Asthma	❑ Feeding difficulties	❑ Snoring
❑ Aspiration	❑ Head injury	❑ Pacifier / thumb sucking habit
❑ Breathing difficulties	❑ Hoarse voice	❑ Tonsillectomy
❑ Chronic cough	❑ Reflux	❑ Vision problems

Please list any other major hospitalizations / surgeries / medical concerns and approximate date(s):

_____

_____

Please list any medications your child takes regularly: _____

_____

Family History: Please list any relevant family history (e.g., speech/language, feeding/swallowing, neurological, allergies, etc.):

_____

Forms completed by: _____ Relationship to patient: _____