Hope Therapies, LLC
Spring Hill, TN 37174
615-241-0122
www.hopetherapies.org

Patient Intake Form
Pediatric

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 Hope Therapies, LLC? _____

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

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: _____

_____

_____

_____

Some of your child's favorite activities / play items: _____

_____

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

Patient Name: _____

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: _____ Self-fed with spoon: _____

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: _____

Medical History

Has your child had any of the following?

❑ Adenoidectomy	❑ Ear (PE) tubes	❑ Sleeping difficulties
❑ Allergies	❑ Feeding difficulties	❑ Snoring
❑ Breathing difficulties	❑ Head injury	❑ Pacifier / thumb sucking habit
❑ Chronic cough	❑ Hoarse voice	❑ Tonsillectomy
❑ Ear infections	❑ Seizures	❑ 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 (speech/language delays, learning difficulties, etc.):

_____

Forms completed by: _____ Relationship to patient: _____