BYC
BECAUSE YOU CAN

Because You Can LLC
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PATIENT INTAKE FORM

Patient Information	
Name: _____ Date of Birth (mm/dd/yyyy): _____ Patient SSN: _____	Today's date: _____ Who referred you to our program?: _____
Name of person completing this form: _____ Relationship to Patient: _____	Name of Referring Doctor: _____

Parent/Guardian Information (if applicable)	
Name(s): _____	
Street Address: _____ _____ City, State: _____ Zip Code: _____	Patient's address: (If different from parent/guardian) Street: _____ City, State: _____ Zip Code: _____
Telephone Number (s): Home: _____ Work/cell: _____	Primary language spoken at home: _____ Need an interpreter? Yes/No
Email address: _____	

Purpose of Visit
What specific questions do you have? _____ _____
Are you interested in looking at specific augmentative communication strategies (e.g., device, technique, symbols, etc.)? _____ _____

Medical History

Date of onset/diagnosis: _____

Please describe the speech/language difficulties:

_____

_____

_____

If known, what is the cause of the speech/language difficulty?

_____

Has the speech/language difficulty changed since first diagnosed? Please describe:

_____

_____

_____

Medications: (please list name and purpose) Example Depakote for seizures

_____

_____

Hearing:
Has your child's hearing been tested?

When: _____

Where: _____

Results:_____

Does your child wear hearing aids, use an FM system or have a cochlear implant? Yes/No

Vision:
Has your child's vision been tested?

When: _____

Where: _____

Results: _____

Does your child wear glasses?

Seizures?

If yes, please specify type and frequency:

.

Does your child experience difficulty **sleeping**?

If yes, please describe:

_____

_____

_____

Feeding/Swallowing:
Does your child exhibit problems with feeding/swallowing?
If yes, please specify:

☐ Dysphagia
☐ Selective ("picky") eater
☐ Drooling
☐ Other (please specify)

_____

_____

Family/ Information History	
People currently living within the household: 1. _____ Age: _____ 2. _____ Age: _____ 3. _____ Age: _____ 4. _____ Age: _____ 5. _____ Age: _____	Do any immediate or extended family members have a history of: Language Disorders? ☐ Yes ☐ No Articulation Disorders? ☐ Yes ☐ No Learning Disabilities? ☐ Yes ☐ No Motor Disorders? ☐ Yes ☐ No Fluency/ Stuttering Problems? ☐ Yes ☐ No If yes to any of the above, please explain: _____ _____ _____

Education/Work Setting (if applicable)		
Name and description: _____		
Address: _____ _____	Phone Number: _____	
Student/Teacher Ratio: _____	Grade (if appropriate): _____	
Special Services: (fill in all that apply)		
Type of Therapy	School, therapist's name, (# sessions x minutes/week)	Private, agency name, therapist's name, (# sessions x minutes/week)
Example	Mary Smith 2x30 minutes/week	Anywhere Rehab, Bob Jones 1x60 minutes/week
Speech Therapy		
Occupational Therapy		
Physical Therapy		
Special Education		
ABA		
Other:		

Behavior	
Describe typical behavior: _____ _____ _____	List preferred toys, foods, songs, videos, etc.: _____ _____ _____
How long will the patient pay attention to an activity he/she is interested in? _____	Describe the patient's personality (e.g., easygoing, rigid, happy, etc.) _____
Is the patient able to easily transition between activities and environments?	Is the patient motivated to interact with peers?
Please comment on the patient's pretend play skills (e.g., combing doll's hair, pushing train on tracks, etc.): _____ _____ _____ _____	Does the patient exhibit aggressive/self-injurious behaviors? If yes, please describe: _____ If yes, if he/she is currently receiving behavioral intervention? If yes, please describe: _____

Communication

Does the patient currently: (Check all that apply)

- ☐ Understand simple directions? Example: _____
- ☐ Understand names for people and objects?
- ☐ Understand names for body parts?
- ☐ Answer simple questions? Example: _____
- ☐ Understand prepositions (in, under, on)?
- ☐Understand color and size words?

Which of the following describe(s) how the patient communicates? (Check all that apply)

- ☐ Pointing, gesturing, vocalizing
- ☐ Eye contact, facial expressions
- ☐ Babbling
- ☐ Pulls person to desired object
- ☐ Objects/ tangible symbols
- ☐ Pictures
- ☐ Communication boards/ book
- ☐ Sign language
- ☐ Single words
- ☐ Two word phrases

☐ Three to four word sentences

☐ Sentences with some errors

☐ Grammatically correct sentences

☐ Writing

☐ Communication device(s)- If yes, please complete page 6

☐ Other (please specify): _____

Please provide examples of the patient's communicative/messages (e.g., vocalizations, signs, picture symbol use, etc.):

_____

If the patient uses communication boards/books/devices to communicate, please provide additional information regarding:

Symbol type:

☐ Text

☐ PECS (Picture Exchange Communication System)

☐ Mayer-Johnson PCS

☐ Photographs

☐ Other

Number of symbols per page/display:

_____

Presentation:

☐ Removable icons

☐ Static Grid

Access:

☐ Point

☐ Symbol exchange

☐ Other: _____

Does the patient communicate to: (Check all that apply)

YES TO ALL

☐ Ask for wants/needs?

☐ Get your attention?

☐ Label people, things, or pictures around him/her?

☐ Ask questions?

☐ Greet people?

☐ Ask for help?

☐ Share information

Is the patient aware of: (Check all that apply)

☐ Who they are and others are

☐ Where they are

☐ Date

What does the patient do when not understood? Please explain (e.g., repeats message, modifies message, stops trying to communicate, etc.):

_____

If the patient speaks, do you have difficulty understanding his/her speech?

If yes, please explain:

_____

Do others have difficulties understanding his/her speech?

If yes, please explain:

_____

**Please email copies of previous communication evaluations in advance of scheduled appointment

Financial/Insurance Information	
Primary Insurance Information:	
Health Insurance Provider: _____	Policy Holder's Name: _____
Policy Holder SSN: _____	HMO or PPO (circle one if applicable) PPO
Policy Number(s) for Patient: _____ _____	Group Number: _____ _____

Secondary Insurance Information (if applicable)	
Health Insurance Provider: _____	**Policy Holder's Name:** _____
Policy Number (s) for Patient: _____	**Group Number:** _____