BYC
BECAUSE YOU CAN

5225 Central Ave, Saint Petersburg, FL 33710

# General Pediatric Intake Form

## DEMOGRAPHIC INFORMATION

**Patient's legal name:**

_____
*Last*

_____
*First*

**Today's date (MM/DD/YYYY):**

_____

**Name of referring provider:**

_____

**Patient's address:**

_____
*Street*

_____
*City* *State* *Zip code*

**Patient's date of birth (MM/DD/YYYY):**

_____

**Patient's SSN:**

_____

**Name of person completing this form:**

_____

**Relationship to patient:**

_____

**Primary language spoken at home:**

_____

**Need an interpreter?** ☐ Yes ☐ No

## PARENT/GUARDIAN INFORMATION

**Parent/Guardian 1**

**Name:** _____

**Phone number(s):**

**Home:** _____

**Cell:** _____

**Work:** _____

**Email address:**

_____

**Parent/Guardian 2**

**Name:** _____

**Phone number(s):**

**Home:** _____

**Cell:** _____

**Work:** _____

**Email address:**

_____

| **Please check your preferred method of contact:**<br><br>☐ Home ☐ Cell ☐ Work ☐ Email | **Please check your preferred method of contact:**<br><br>☐ Home ☐ Cell ☐ Work ☐ Email |
|---|---|
| **Address:** *(if different from patient's)*<br><br>_____<br>*Street*<br><br>_____<br>*City* *State* *Zip code* | **Address:** *(if different from patient's)*<br><br>_____<br>*Street*<br><br>_____<br>*City* *State* *Zip code* |

## 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.)?** ☐ Yes ☐ No

## 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 the onset/initial diagnosis? Please describe:**

_____

**Does the patient take any medication(s)?** ☐ Yes ☐ No

**If yes, please list the name and purpose of each medication:**

| *Name* | *Purpose* |
|---|---|
| | |
| | |

**Hearing**

**Has the patient's hearing been tested?**

☐ Yes
☐ No

**If yes:**

**Date of most recent evaluation:**

_____

**Name of provider/facility:**

_____

**Results:**

_____

**Does the patient wear hearing aids, use an FM system, or have a cochlear implant?**

☐ Yes
☐ No

**Vision**

**Has the patient's vision been tested?**

☐ Yes
☐ No

**If yes:**

**Date of most recent evaluation:**

_____

**Name of provider/facility:**

_____

**Results:**

_____

**Does the patient wear glasses?**

☐ Yes
☐ No

**Does the patient experience seziures?**

☐ Yes
☐ No

**Does the patient experience difficulty sleeping?**

☐ Yes
☐ No

| **If yes, please describe the type and frequency:** | **If yes, please describe:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Feeding/swallowing** *(if applicable)*

**Does the patient exhibit problems with feeding/swallowing?** ☐ Yes ☐ No

**If yes, please specify:**

☐ Dysphagia
☐ Selective ("picky") eater
☐ Drooling
☐ Other: _____

## FAMILY HISTORY

**People currently living in the household:**

_____
*Relationship to patient* *Age*

_____
*Relationship to patient* *Age*

_____
*Relationship to patient* *Age*

_____
*Relationship to patient* *Age*

_____
*Relationship to patient* *Age*

_____
*Relationship to patient* *Age*

**Please check if any immediate/extended family has a history of the following:**

☐ Articulation disorders
☐ Language disorders
☐ Learning disabilities
☐ Fluency/stuttering problems
☐ Motor disorders

**If yes to any of the above, please explain:**

_____
_____
_____
_____

**EDUCATION SETTING** *(if applicable)*

**Name and description:**

_____

**Address:**

_____
*Street*

_____
*City* *State* *Zip code*

**Phone number:**

_____

**Email:**

_____

**Student-to-teacher ratio:**

_____

**Grade level:** *(if applicable)*

_____

**Special Services** *(fill in all that apply)*

**Speech Therapy** ☐ Yes ☐ No

**If yes:**

**Name of therapist/facility:**
*Example: Mary Smith, Anywhere Rehab*

_____

**# of sessions x minutes/week**
*Example: 3x/30 minutes*

_____/_____

**Occupational Therapy** ☐ Yes ☐ No

**If yes:**

**Name of therapist/facility:**

_____

**# of sessions x minutes/week**

*Example: 3x/30 minutes*

_____/_____

**Physical Therapy** ☐ Yes ☐ No

**If yes:**

**Name of therapist/facility:**

_____

**# of sessions x minutes/week**

*Example: 3x/30 minutes*

_____/_____

**Special Education** ☐ Yes ☐ No

**If yes:**

**Name of therapist/facility:**

_____

**# of sessions x minutes/week**

*Example: 3x/30 minutes*

_____/_____

**ABA Therapy** ☐ Yes ☐ No

**If yes:**

**Name of therapist/facility:**

_____

**# of sessions x minutes/week**

*Example: 3x/30 minutes*

_____/_____

**Other:**

**Name of therapist/facility:**

_____

**# of sessions x minutes/week**

*Example: 3x/30 minutes*

_____/_____

**BEHAVIOR**

**Please describe the patient's typical behavior:**
*Example: When he's sleepy or wants to lay down, he'll grab his blanket and he'll give me his bottle for milk if it's empty. He'll play with other kids even if they're a little older than him. If I tell him to do something or to give something, he'll do it.*

_____

_____

_____

_____

_____

_____

**Please list the patient's preferred toys, foods, songs, videos, etc.:**
*Example: He likes books, plays with toy cars, balls, balloons, swings, bubbles, and likes to go for walks. He likes Kung Fu Panda, Madagascar, and Cocomelon.. He eats soup, fries, chicken nuggets, rice, and beans. He likes The Itsy Bitsy Spider and Wheels on the Bus.*

_____

_____

_____

_____

_____

_____

**How long will the patient pay attention to an activity they are interested in?**

_____

**Describe the patient's personality:**
*Example: Easygoing, rigid, playful, happy, shy..*

_____

**Is the patient able to easily transition between activities and environments?**

☐ Yes

☐ No

**Please comment on the patient's pretend play skills:**
*Example: She will pretend to be on the phone, comb a doll's hair, push trains on tracks.*

_____

_____

**Is the patient motivated to interact with peers?**

☐ Yes

☐ No

**Does the patient exhibit aggressive/self-injurous behaviors?**

☐ Yes

☐ No

**If yes, please describe:**

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |

**COMMUNICATION**

**Does the patient currently:** *(check all that apply)*

☐ Understand simple directions? *(Example: put it back, sit down, give it to me.)*
☐ Understand names for people and objects?
☐ Understand names for body parts?
☐ Answer simple questions?
☐ Understand prepositions (e.g. – in, under, on)?
☐ Understand color and size words (e.g. – red, big, small)?

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

☐ Babbling
☐ Communication boards/books
☐ Communication device(s)
☐ Eye contact, facial expressions
☐ Grammatically correct sentences
☐ Objects/tangible symbols
☐ Pictures
☐ Pointing, gesturing, vocalizing
☐ Sentences with some errors
☐ Single words
☐ Sign language
☐ Three- to four-word sentences
☐ Two-word phrases
☐ Writing
☐ Other: _____

**Please provide examples of the patient's communicative/messages (e.g. – vocalizations made, signs/pictures/symbols used, 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:** _____

**Layout/presentation:** ☐ Removable icons ☐ Static grid

**Access:** ☐ Point ☐ Symbol exchange ☐ Other: _____

**Does the patient communicate in order to:** *(check all that apply)*

☐ Ask for wants/needs

☐ Who they are/who others are

☐ Get your attention

☐ Where they are

☐ Ask questions

☐ Greet people

☐ Ask for help

☐ Share information

**What does the patient do when not understood? Please explain:**
*Example: Repeats messages, modifies messages, stops trying to communicate, etc.*

_____

**If the patient speaks, do you have difficulty understanding them?** ☐ Yes ☐ No

**If yes, please explain:**

_____

**Do others have difficulty understanding their speech?** ☐ Yes ☐ No

**If yes, please explain:**

_____

## FINANCIAL/INSURANCE INFORMATION

| **Primary insurance** | **Secondary insurance** *(if applicable)* |
|---|---|
| **Health insurance provider:** | **Health insurance provider:** |
| _____ | _____ |
| **Policy holder's legal name:** | **Policy holder's legal name:** |
| _____ | _____ |
| *Last* *First* | *Last* *First* |
| **Policy number:** | **Policy number:** |
| _____ | _____ |
| **Group number:** | **Group number:** |
| _____ | _____ |
| **Check which applies:** | **Check which applies:** |
| ☐ HMO ☐ PPO ☐ N/A | ☐ HMO ☐ PPO ☐ N/A |
| **Primary Care Physician's (PCP) name:** | **Primary Care Physician's (PCP) name:** |
| _____ | _____ |
| **PCP's phone number:** | **PCP's phone number:** |
| _____ | _____ |