Speech Therapy Solutions Montana

2615 Colonial Drive

Helena, Montana 59601

Phone: (406) 422-4213

Fax: (406) 924-1903

Today's Date: _____

Child's Name:_____

Birthdate: _____

Sex: F M

Physical Address:_____

Phone: ___ Text: Y N

_____ Carrier: _____

Guardian/Responsible Party Information:

Please circle: Mother Stepmother Guardian

Name: _____

Birthdate: _____

SS#: _____

Phone: _____

Carrier: _____

E-mail: _____

Address - if not the same as client:

_____

Is this person financially responsible? ☐ Y ☐ N

Does the client live with this person? ☐ Y ☐ N

May we leave a detailed message via (check all that apply)

Text: ☐ Y ☐ N Email: ☐ Y ☐ N Phone: ☐ Y ☐ N

Please circle: Father Stepfather Guardian

Name: _____

Birthdate: _____

SS#: _____

Phone: _____

Carrier: _____

E-mail: _____

Address - if not the same as client:

_____

Is this person financially responsible? ☐ Y ☐ N

Does the client live with this person? ☐ Y ☐ N

May we leave a detailed message via (check all that apply)

Text: ☐ Y ☐ N Email: ☐ Y ☐ N Phone: ☐ Y ☐ N

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent

☐ Adoptive Parents ☐ Parent and Stepparent ☐ Other: _____

Other children in the family:

Name Age Sex Grade Speech/Hearing Problems

_____

_____

_____

Child's race/ethnic group:

☐ Native American ☐ African American ☐ Caucasian, Non-Hispanic

☐ Hispanic ☐ Asian or Pacific Islander ☐ Other: _____

Insurance Information

PLEASE FILL OUT COMPLETELY IF YOU WOULD LIKE THIS EVALUATION AND/OR TREATMENT PROCESSED THROUGH YOUR INSURANCE COMPANY:

Primary Insurance Information:

Ins. Company: _____ Co-Payment Amount: $_____

Plan Type: _____ Ins. Phone: _____

Primary ID: _____ Address: _____

Policy/Group #: _____ _____

Plan/Program: _____ _____

Subscriber: _____ Relation to patient: _____

Birth Date: _____ SSN#: _____

Secondary Insurance Information:

Ins. Company: _____ Co-Payment Amount: $_____

Plan Type: _____ Ins. Phone: _____

Primary ID: _____ Address: _____

Policy/Group #: _____ _____

Plan/Program: _____ _____

Subscriber: _____ Relation to patient: _____

Birth Date: _____ SSN#: _____

Responsible Party Information

Who is financially responsible?

Full Name: _____ Birthdate: _____ Sex: ☐ F ☐ M

Relation to patient: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

_____ Cell Carrier: _____ (for text reminders)

SSN #: _____ Insurance: _____

Email: _____

* May we leave a detailed message via (check all that apply): Text: ☐Y ☐N Email: ☐Y ☐N Phone: ☐Y ☐N

Responsible Party (1) Employer(s)?

Business Name: _____ Business Phone: _____

Supervisor: _____ Fax Number: _____

Address: _____

_____

Email: _____

Responsible Party (2) Employer(s)?

Business Name: _____ Business Phone: _____

Supervisor: _____ Fax Number: _____

Email Address: _____

Emergency Contacts

Emergency Contacts: (Not listed above)

Doctor's Name: _____ Doctor's Phone: _____

Full Name: _____ May we contact in case of emergency? ☐ Y ☐ N

Relation to patient: _____ Daytime Phone: _____

Full Name: _____ May we contact in case of emergency? ☐ Y ☐ N

Relation to patient: _____ Daytime Phone: _____

Full Name: _____ May we contact in case of emergency? ☐ Y ☐ N

Relation to patient: _____ Daytime Phone: _____

Feeding & Swallowing Intake

Signature: _____ Date: _____

Was the child breast fed? _____

Was child fed through a feeding tube? ☐ **Yes** ☐ **No**

If yes, for how long? _____

EATING HABITS

What does your child eat in a typical day? List main foods & amounts per meal.

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

How long does it take for your child to finish a meal? _____

_____

_____

What are your child's favorite foods? _____

_____

_____

What foods does your child dislike? _____

_____

_____

In what position is your child most comfortable eating? Check all that apply

☐ **Highchair** ☐ **Chair at table** ☐ **Standing** ☐ **Lap**

☐ **Laying Down** ☐ **Other**

What utensils have been introduced? Please indicate at what age. Check all that apply.

_____**Pacifier**	_____**Bottle**	_____**Fingers**
_____**Spoon**	_____**Fork**	_____**Sippy Cup**
_____**Straw**	_____**Cup**	_____**Other**

Is any adaptive equipment being used during feedings?

_____

If your child is not using a bottle, when did they transition to a cup?

_____

Does your child self-feed?

_____

At what age did child start self-feeding?

_____

What kinds of food does your child eat regularly? Please indicate at what age. Check all that apply.

_____Breastmilk **_____Formula** **_____Thin liquids**

_____Thickened liquids **_____Pureed food** **_____Mashed table food**

_____Chopped table food **_____Regular table food** **_____Other**

If your child is eating solids, at what age was solid food introduced?

_____

Does your child take any nutritional supplements? If yes, please indicate product, amount & frequency. _____

How do you if your child is hungry?

_____

How do you know when your child is full?

_____

Is your child having trouble losing weight?

_____

Is your child having trouble gaining weight?

_____

Please check off any behaviors that apply to your child during meals:

_____ Choking
_____ Eats too much
_____ Difficulty swallowing
_____ Fussy, cranky
_____ Pushing food out
_____ Gagging
_____ Holding food in mouth
_____ Noisy breathing
_____ Gagging
_____ Vomiting
_____ Refusal to eat
_____ Mouth closing
_____ Hyperextension
_____ Food or liquid coming out of nose
_____ Eats too little
_____ Trouble breathing
_____ Spitting out food
_____ Delayed swallow
_____ Crying
_____ Pocketing food in mouth
_____ Wet quality to voice
_____ Reflux
_____ Falling asleep
_____ Head turning
_____ Stiffening
_____ Other behaviors

Does your child demonstrate negative behaviors during mealtime?

Please check all that apply.

_____ Throws food
_____ Spits food out
_____ Leaves table before done
_____ Messy eater
_____ Trouble with self-feeding
_____ Trouble with chewing
_____ Trouble with swallowing
_____ Refusal to eat
_____ Takes food from other's plate
_____ Other _____

Does your child still use a pacifier? _____

Does your child have difficulty with speech, feeding and/or movements with his/her mouth?

_____

Does your child dislike to be touched around his/her mouth?

_____

Does your child drool? If yes, please indicate often, infrequent or occasionally.

_____

What seems to help (or not help) your child during mealtimes?

_____

_____

_____