Blossom Therapies of Florida
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OFFICE USE ONLY	
ID	
DATE	
OTHER	

PATIENT INFORMATION

To Parent/Guardian: Please answer the following questions about your child.

Please include copies of the following documents:

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).

CHILD'S INFORMATION			
FULL NAME	GENDER ☐ Male ☐ Female	DOB	
NAME OF SCHOOL	GRADE	AGE	
PRIMARY CARE PHYSICIAN (PCP)	PCP PHONE		
DESCRIBE YOUR MAIN CONCERNS When the problem was first noticed, who noticed it, and where the problem occurs.			
How does your child react to being misunderstood or unable to communicate?	☐ Tries again/revises ☐ Becomes angry/frustrated ☐Other: ☐ Gives up ☐ Doesn't notice		
Why are you seeking speech-language services for your child?			
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?			
How did you learn about us?			
In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. ☐ None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

FAMILY'S INFORMATION			
With whom does your child live? (Check all that apply)	☐ Biological parent(s) ☐ Adoptive parent(s) ☐ Legal guardian(s) ☐ Grandparent(s) ☐ Sibling(s) ☐ Other:		
In the table to the right, list all family members who live in the same home as your child.	**NAME**	**AGE**	**RELATION TO CHILD**
Do you have any pets? (List name and type)			

PARENT 1 INFORMATION		
FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
PLACE OF EMPLOYMENT	POSITION	

PARENT 2 INFORMATION		
FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
PLACE OF EMPLOYMENT	POSITION	

Are there family circumstances that would be helpful to share with us? (e.g., custody arrangements)		
Are there any other languages spoken in the home? If yes, which language(s) and how often?		
Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

CHILD'S HEALTH BACKGROUND				
Describe your pregnancy, including any complications.				
Describe your labor/delivery, including any complications.				
TYPE OF BIRTH (check all that apply)	☐ Spontaneous (not induced)	☐ Induced	☐ Vaginal	☐ C-section
BIRTH PLACE (hospital/birth center)		BIRTH ATTENDANT (physician, midwife)		
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	NICU ☐ Yes ☐ No How long?	
Were there any complications after birth or during the first few weeks?	☐ Difficulty breathing ☐ Jaundice	☐ Difficulty feeding ☐ Seizures	☐ Birth defect ☐ Other:	
Has your child's hearing been tested?	☐ Yes ☐ No If yes, when and where?		☐ Passed ☐ Did not pass	
Describe any serious illnesses, injuries, or medical procedures your child has experienced.				
List any environmental or food allergies.				
List any routine medications your child is currently taking or has taken long term.				
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.				

CHILD'S STRENGTHS AND FAVORITES	
Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE TOYS	
FAVORITE MOVIES	
FAVORITE BOOKS	

CHILD'S FEEDING DEVELOPMENT		
BREASTFED from ________ mos until ________ mos	FORMULA FED from ________ mos until ________ mos	BOTTLE until ________

At what age did your child begin using the following?	☐ SIPPY CUP ________ months ☐ STRAW ________ months ☐ OPEN CUP ________ months ☐ UTENSILS ________ months
Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc.	

FAVORITE FOODS	FOOD AVERSIONS

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT	
At what age did your child begin:	☐ BABBLING (bababa) ________ months ☐ JARGON (bada bama) ________ months ☐ FIRST WORD____________ at ________ months ☐ TWO-WORD COMBO (more milk) ________ mo ☐ THREE-WORD COMBO ________ months/years ☐ SENTENCES ________ months/years ☐ READING LETTERS ________ years ☐ WRITING LETTERS ________ years ☐ READING WORDS ________ years ☐ WRITING WORDS ________ years ☐ READING SENTENCES ________ years ☐ WRITING SENTENCES ________ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	☐ Parent(s) ☐ Sibling(s) ☐ Peers ☐ Teacher(s) ☐ Extended Family ☐ Strangers _______% _______% _______% _______% _______% _______%
Has your child's speech-language been evaluated? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

______________________________ ______________________________

PARENT/GUARDIAN SIGNATURE DATE