Bi-County Speech, Occupational & Physical Therapy Bilingual Spanish and English

Welcome to our family!

Thank you for scheduling an evaluation with us. Please fill out the following paperwork and forward it back to us before the day of your appointment. There a few things that we want you to know:

Please bring socks. We are a no shoe facility when inside our treatment area.

Also, the evaluation takes 48 hours to be written by the therapist. Once it has been written by the therapist we need to send it to your doctor to have it signed.

When the doctor sends it to back we need to forward the evaluation to the insurance for authorization.

When we obtain the authorization one of our staff member will contact you to add you to the schedule

4301 S. Flamingo Rd Suite # 101
Davie, FL 33330
Phone # 954-312-3449
Fax #954-251-2752

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INTAKE INFORMATION

Patient Name: **DOB:**
Date of Appointment:

***Please take some time to fill out the information below. We ask that you return the information digitally, so that we have the information before the evaluation appointment time. Thank you.**

FAMILY BACKGROUND :

- Child lives with:
  Mother_____Father_____
  Siblings name and ages: _____ , _____, _____, _____
- Languages spoken in the home: _____, _____, _____
- Discipline: ☐adequate ☐permissive ☐strict ☐inconsistent

DEVELOPMENTAL MILESTONES:

Age: crawled _____, walked_____, babbled_____, first words_____

Aversions: ☐ touch _____ ☐ smell _____ ☐ sounds _____
☐ tastes _____ ☐ face washing ☐ teeth brushing
☐ food ☐ other:

Demeanor: ☐ friendly ☐ shy ☐ social
☐ active ☐ emotional

REASON FOR REFERRAL:

☐ Academic concerns
☐ Sensory processing irregularities
☐ Fine/gross motor delay
☐ Social skills delay
☐ Attention deficits
☐ Developmental delay
☐ Behavioral concerns
☐ Speech concerns
☐ Language concerns
☐ Processing of information
☐ Fluency concerns
☐ Voice concerns
☐ Feeding

PRENATAL HEALTH:

Weeks of Gestation: Birth Weight: Length:
Complications: _____

MEDICAL HISTORY:

☐ Difficulties hearing ☐ Heart problems ☐ Diabetes ☐ Allergies
☐ Breathing problems ☐ Asthma ☐ Recurrent ear infections

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☐ Seizures ☐ GERD (reflux) ☐ Other :_____
Has your child been seen by a Neurologist? ☐ YES ☐ NO

MEDICATIONS:
☐ Current medications:_____
☐ No medications at this time.

CURRENT FORM (S) OF COMMUNICATION:

☐ Gestures	☐ Physical directing	☐ Vocalizations
☐ Babbling	☐ Jargon	☐ Echolalia
☐ 1- word utterances	☐ Occasional phrases	☐ Augmentative Device
☐ 2-word phrases	☐ Code switching	
☐ Sentences	☐ Other: _____	

VISION

☐ Appears WNL	☐ Visually Impaired	☐ Wears Glasses	☐ Nystagmus
☐ Strabismus	☐ Tracks Horizontally	☐ Tracks Vertically	
☐ Smooth/Jerky	☐ Convergence	☐ Other: _____	

HEARING

☐ Appears WNL	☐ Apparent Hearing Deficits	☐ Wears Hearing Aide(s)
☐ Startles Easily	☐ Sign Language	☐ Auditory Processing
☐ AAC Device: _____		

EDUCATION:
☐ School ☐ Preschool/Daycare ☐ Home

Name of School:_____

- Has your child been evaluated by the school district?
  _____
- Does your child currently have an: ☐IEP ☐IFSP ☐other:_____
  - If yes, please bring a copy to the initial evaluation session.
- Does your child currently have a diagnosis? ☐Yes ☐No
  - If yes, please list the diagnosis:_____

PREVIOUS INTERVENTION:
☐ No history of previous therapy.
☐ Has received:

THERAPIES:

OT	☐ Current (___x/wk)	☐ Previous (___x/wk)
PT	☐ Current (___x/wk)	☐ Previous (___x/wk)
ST	☐ Current (___x/wk)	☐ Previous (___x/wk)

☐ Other :_____

FEEDING/ORAL MOTOR:

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Welcome to our family!

- ☐ Uses Utensils to Feed
- ☐ Drinks From: (Bottle/Sippy Cup/ Regular Cup)
- ☐ Tolerates (Variety/Limited) Food Textures:_____
- ☐ Chokes when eating or drinking? Y N How often? _____

SOCIAL BEHAVIOR OBSERVATION:

- ☐ Auditory/visually alert and attentive
- ☐ Age-appropriate attention span
- ☐ Appropriate attending and responding behaviors
- ☐ Cooperative
- ☐ Friendly
- ☐ Sociable
- ☐ Interactive
- ☐ Appropriate use of eye contact
- ☐ Easily separated from parent (s)
- ☐ Well-behaved
- ☐ Restricted affect
- ☐ Separation anxiety
- ☐ Auditory/visually alert yet inattentive
- ☐ Short attention span
- ☐ Inconsistent attending and responding
- ☐ Uncooperative
- ☐ Easily frustrated
- ☐ Immature
- ☐ Non-interactive
- ☐ Poor eye contact
- ☐ Hyperactive
- ☐ Distracted
- ☐ Impulsive
- ☐ Other

I attest that the information in this document is true and accurate.

_____ _____

Name of person filling out this form Relation to patient

_____ _____

Name of person filling out this form Relation to patient

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