7711 East 111th Street South, Suite 127, Tulsa, OK 74133
(P): (918) 691-3212; (F): (918) 364-4276; alternate (918) 369-4551

PATIENT HISTORY/INTAKE FORM

Today's Date: ___________________________ Referral source: _______________________________

Name: ____Date of Birth__________________

What are your concerns regarding your child?:

____

____

____

Birth History: Please describe any problems/concerns with pregnancy (serious accidents, substance abuse, illness, medications, etc.), delivery, NICU stay, need for oxygen, need for ventilator, medications provided in hospital, etc.

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____

Circle where appropriate:

Feeding problems	Seizures	Birth Defects
Breathing Problems	Cesarean Delivery	Apnea
Induced Labor	Breech Birth	Yellow color/Jaundice
Respiratory Problems	Sucking/Swallowing Problems	

Medical History: (circle where appropriate)

Allergies	Asthma	Bronchitis	Seizure Disorder
Earaches	Draining Ear	Chicken Pox	Mental Illness
RSV	Pneumonia	Physical Impairments	

Please describe any medical problems you/your child is experiencing including past illness, hospitalizations, surgeries, syndromes, etc. Provide approximate dates/ages when illness/condition occurred:

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Did you/your child pass the Newborn Hearing Screening in the hospital? If not, were you/was the child re-tested? Please describe:

____

____

Ear Infections (how many): ____

Do you/does child have tubes? Date of surgery____________________________________

Primary Care Physician/Pediatrician (name and contact information including fax):

____

List all medications you/your child is currently taking: ___________________________

Any negative reactions to these medications? Describe: ___________________________

DEVELOPMENTAL MILESTONES (For pediatric patients)

Does/Did your child babble and coo?
Does/Did your child imitate sounds or words?
When did you r child say his/her first words?
When did your child begin combining words?
When did your child begin using sentences?
How does your child communicate to request what he/she wants or needs?

How would you describe your child's speech production?

How would you describe your child's ability to follow commands?

How does your child communicate with children of his/her age?

How would you describe your child's physical development?

When did your child take his/her first steps?

If your child is school aged, describe how your child functions in the classroom:

If your child is school aged, describe your child's ability to read:

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Are there any additional speech, language, learning, attention, or hearing problems in your family? If yes, please describe.

Have you/or your child seen any other specialists (physicians, ENT, neurologist, Physical Therapist, Occupational Therapist, etc.)? If yes, indicate type of specialist, dates seen and the professional's conclusions or recommendations.

Provide any additional information or concerns that might be helpful in the evaluation and development of your/or your child's treatment plan.

On occasion, photographs or video may be taken of a therapy session for monitoring progress, presentations, and/or community events. I give my permission for my child to be photographed and/or videoed, with the understanding I will be notified prior to either.

____

Parent signature

Person completing form: ____

Relationship to child: ____

Signed: ___________________________________ Date: _____________________

*In the event you need to reschedule or cancel your appointment, kindly contact your clinician 24 hours prior to your scheduled visit, so we may offer the slot to another family. Following three no show/no call events, Prohab reserves the right to terminate the patient-provider relationship and you may be charged a fee.