PATIENT INTAKE FORM AND CONSENT

CHILD'S NAME: ________________________ AGE: ________ DATE OF BIRTH: ________________

SCHOOL: ________________________________ GRADE: ________________

ADDRESS: ____
Street City State Zip

CELL PHONE: ________________________ REFERRED BY: ________________________

NAME OF PARENT(S) OR LEGAL GUARDIAN(S): ________________________

PREGNANCY AND BIRTH:
List any problems, if any, during pregnancy, delivery, and/or birth: ________________________
____

DEVELOPMENTAL HISTORY:
List the approximate age at which your child achieved the following developmental milestones:
First steps: ______________ Babble (make sounds, but not words): ______________ Said first words: ______________
Combined words (e.g., "more juice"): ____________Used complete sentences (e.g., "I want it"; "Me don't like it"): ______________

MEDICAL HISTORY & RESPIRATION: Check what pertains to your child **most** of the time.

1. When awake, lips are ☐ together ☐ apart
2. When asleep, lips are ☐ together ☐ apart
3. Is snoring or audible breathing present when asleep? ☐ yes ☐ no
4. Does your child have difficulty getting air through their nose? ☐ yes ☐ no
5. Does your child have difficulty putting lips together? ☐ yes ☐ no
6. Does your child frequently have a sore throat? ☐ yes ☐ no
7. Does your child have respiratory allergies? ☐ yes ☐ no
8. Does your child have asthma? ☐ yes ☐ no
9. Does your child have a history of ear infections? ☐ yes ☐ no
10. Does your child have a history of frequent tonsillitis? ☐ yes ☐ no If yes, how frequent? ______________
11. Have your child's tonsils been removed? ☐ yes ☐ no If yes, when? ______________
12. Have your child's adenoids been removed? ☐ yes ☐ no If yes, when? ______________
13. Has your child been diagnosed with sleep apnea? ☐ yes ☐ no
14. Has your child had any other serious injury, surgery, and/or medical diagnosis? If yes, please explain. ______________
    ____
15. Has your child had their hearing tested? ☐ yes ☐ no Date/Location/Results: ______________
16. Has your child had their vision tested? ☐ yes ☐ no Date/Location/Results: ______________
17. Has your child been previously tested for speech/language delays? ☐ yes ☐ no Date/Location/Results: __________
    ____
18. Has your child ever had speech therapy? ☐ yes ☐ no Date/Location/Goals: ______________
    ____
19. Has your child ever received any other evaluation or therapy (e.g., physical therapy, occupational therapy, vision therapy, counseling, etc.)? ________________________

ORAL HABITS:

1. Child currently sucks ☐ thumb ☐ fingers or ☐ uses a pacifier.
2. Child used to suck ☐ thumb ☐ fingers or ☐ use a pacifier. When did he/she stop? ________________
3. Does your child currently bite his/her fingernails? ☐ yes ☐ no
4. Does your child chew/suck on objects, such as ☐ straws ☐ pencils ☐ clothing ☐ toys ☐ hair ☐ other? ______________
   ____

EATING AND DRINKING: Check what pertains to your child **most** of the time.

1. Does your child take ☐ big bites ☐ small bites or ☐ average bites of food?
2. Does your child eat ☐ quickly ☐ slowly or ☐ at an average pace?
3. When chewing, child's mouth is ☐ open or ☐ closed?
4. Does your child have difficulty swallowing dry foods without liquid? ☐ yes ☐ no
5. Does your child need to drink after each bite to get the food down? ☐ yes ☐ no
6. Does your child have excessive indigestion after eating? ☐ yes ☐ no
7. Has your child been diagnosed with a tongue-tie or lip-tie? ☐ yes ☐ no
8. Did your child ever have difficulty nursing, taking a bottle, or eating as an infant? ☐ yes ☐ no

LANGUAGE BACKGROUND:

1. What language(s) is/are used in the home? ________________________________
2. What was your child's first language? ________________________________
3. What language does your child use the most? ________________________________
4. What language does your child understand best? ________________________________

PARENT/FAMILY OBSERVATIONS:

1. Does your child currently have difficulty saying any sounds? ☐ yes ☐ no
2. Does your child use gestures or words to communicate? ☐ gestures ☐ words
3. Can your child tell you what happened in a TV show, movie, or at school in a way that you understand? ☐ yes ☐ no
4. Is your child able to express feelings appropriately? ☐ yes ☐ no
5. Is your child able to ask for help? ☐ yes ☐ no
6. Does your child start conversations with other children? ☐ yes ☐ no
7. Is your child able to stay on one topic during conversation? ☐ yes ☐ no
8. Does your child ever have difficulty talking in certain situations or places? ☐ yes ☐ no
9. Does your child look at the speaker during conversations? ☐ yes ☐ no
10. Does your child have trouble following directions? ☐ yes ☐ no
11. Does your child have trouble understanding what you say? ☐ yes ☐ no
12. Do you have trouble understanding your child? ☐ yes ☐ no
    If yes, what percentage of your child's speech do you understand?____________%
13. Does your child have behavior problems? ☐ yes ☐ no
14. Does your child have trouble making friends? ☐ yes ☐ no
15. Does your child have trouble learning new concepts? ☐ yes ☐ no
16. Would you consider your child to be shy? ☐ yes ☐ no

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(949) 365-5858

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17. How would you describe your child's speech/language abilities? What are your concerns? ______________________________
____
____
____

18. Please include any other information you think would be helpful in evaluating your child. ______________________________
____
____
____

CONSENT:

☐ I give consent for Melissa Beck, a certified Speech-Language Pathologist and Orofacial Myofunctional Therapist, to conduct a swallowing and/or speech evaluation which may include an orofacial exam and other swallow or speech related tests that she deems necessary to make a clinical diagnosis.

☐ I understand that payment of the assessment fee of $275.00 is due and payable at time of the evaluation.

☐ I give consent for Melissa Beck, MA, CCC-SLP, OMT to communicate her findings by consultation, phone, e-mail, fax, or postal service with Dr. ____.

____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN OF MINOR DATE

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AUTHORIZATION AND CONSENT TO USE PHOTOGRAPH OR VIDEO RECORDINGS

PATIENT NAME: ____

I, the undersigned, do hereby consent and agree that OC Orofacial Myology, Inc., and its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/after photos etc.

(Mark your choice below)

☐ **YES** -- Including full face.

☐ **YES** -- But please exclude any recognizable facial features.

☐ **NO** -- Photographs may only be used for medical record keeping and treatment planning only.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

(Mark your choice below)

☐ **YES** -- Use my name.

☐ **NO** -- I prefer to remain anonymous.

By signing this form below, I confirm that this consent form has been explained to me in terms that I understand. I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I understand that there will be no financial or other remuneration for the recording, either for initial or subsequent transmission or playback. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Name of Authorizing Individual: ______________________________ Relationship to Patient: ________________________

Signature: ____ Date: ______________________________________

Witness: ____ Date: ______________________________________

If this release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.

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