TheraKids INC.

Specializing in Pediatric Speech, Language, Feeding, and Swallowing

Tethered Oral Tissues - One Year Plus

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Parents' / Legal Guardians' Names: _____
Home Address: _____ Home Phone: (____)_____
_____ Cell Phone: (____)_____
County: _____ Work Phone:(____)_____
Email Address: _____
Physical address listed above is for mom / dad / caregiver _____
Can we contact you via text / e-mail regarding your child's therapy schedule and follow-up with therapy appointments?
Yes **No**

Diagnosis(es):_____
_____

Medical Insurance Company:_____
Policy Number:_____
Who will be responsible for payments:_____
Emergency contact information:
Name:_____ Relationship:_____
Phone Number:_____

Child's Pediatrician:_____
Address:_____
Zip Code:_____ Phone:_____ Fax:_____
How long has your child been under this physician's care?:_____

Concerns for child/reason for evaluation:

____ Speech: The sounds your child uses in speech.
____ Feeding/Swallowing: Child is not eating enough foods, is a picky eater, doesn't like certain textures of foods, is a messy eater, has trouble swallowing foods.
____ Oral Motor: May have oral ties/tethered oral tissues, may not move mouth appropriately when eating, may not move mouth appropriately when speaking.

What do you hope to gain from today's evaluation? _____
_____
_____

When did you first notice this problem(s)? _____
_____

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therakidsinc.com

Pregnancy, Labor, and Delivery:

1. List any problems or complications during pregnancy (i.e.: gestational diabetes, eclampsia, maternal seizures, accidents/injuries, etc.):
   _____
   _____

2. List all medications/drugs taken during pregnancy (i.e.: prenatal vitamins, medications for high blood pressure, medications for seizures, cocaine, heroin, etc.):
   _____
   _____

3. List any problems or complications during labor and/or delivery (i.e.: cord wrapped around neck, breech delivery, anoxia/"blue" at birth, respiratory distress, induced birth, limpness, stiffness, etc.):
   _____
   _____

4. Pregnancy: ___ Full Term ___Premature
   Length of Gestation:_____
   Length of total labor:_____ Difficult labor: __ Yes __No
   Delivery Type: __Vaginal __C-section If C-section, what type: __ Emergency __ Planned
   Child's birth weight: _____lbs. _____oz.
   Elaborate on above delivery complications:_____
   _____
   _____
   _____
   Length of hospitalization for child:_____
   Complications at birth:
   __Jaundice __Cyanosis __Congenital defects __Breathing Difficulties
   Other:_____

   Was there a need for:
   __Oxygen __Transfusions __Tube Feedings
   If so, please explain:_____
   _____

   Were there any feeding difficulties in infancy: __Yes __No
   Explain:_____
   _____

5. List any problems complications your child had after birth, as well as any medical conditions/illnesses your child was/has been diagnosed with (e.g.: poor feeder, respiratory distress, seizures, etc.):
   _____
   _____
   _____
   _____

Therapist's Notes:_____
_____
_____
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Developmental and Medical History:

1. How old was your child when he/she:

Sat alone: _____ Stood: _____ Crawled: _____
Walked alone: _____ Dressed self: _____ Toileted:_____
Babbled: _____ Used first words: _____ Combined words: _____
Used sentences: _____ Fed self:_____

2. Currently, what is your child's main way he/she communicates?

____Crying/Whining _____2 & 3 word phrases ____ Making noises
____Complete sentences _____Gesturing/Pointing ____Single words
If less than 10 words, please list_____

3. Language(s) spoken in the home: _____

Does your child speak this language? YES NO
Does your child understand this language? YES NO
Does your child speak English? YES NO
Does your child understand English? YES NO

4. Is your child easily understood by:

You? YES NO **Other family members?** YES NO **People outside the home?** YES NO

5. Check all below that your child has a history of:

___ High fevers ___ Ear infections ___ Seizures ___ Mouth breathing ____Frequent colds
___ Hoarseness ___Acid Reflux ___ Swallowing problems ___ Feeding problems
___ Constipation/Diarrhea
___ Allergies: __None __Seasonal __Food __Other
Please list all allergies: _____
_____

Other:_____

3. Child's general health at present: __Good __Fair __Poor

4. List any accidents / injuries / surgeries / major illnesses / diseases your child has incurred and their dates:

_____ _____
_____ _____
_____ _____
_____ _____

5. List all medications your child currently takes:

Medication	Dose (i.e.: mg)	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Has your child ever had his/hearing tested? YES NO
If YES:
Date:_____
Results_____
Does your child have problems with his/her hearing? If YES, please explain:
_____

7. Has your child ever had his/her vision tested? YES NO
If YES:
Date:_____
Results_____
Does your child have problems with his/her hearing? If YES, please explain:
_____

8. Has your child had any previous testing?

			DATE:	RESULTS:
MRI	NO	YES	_____	_____
CT	NO	YES	_____	_____
EEG	NO	YES	_____	_____
Developmental/Educational	NO	YES	_____	_____
Psychological/Psychiatric	NO	YES	_____	_____
Neurological	NO	YES	_____	_____

9. Has your child achieved skills and then lost them: __Yes __No
   Explain (what and when):_____
   _____
   _____

10. Does your child attend school? YES NO
    School Name:_____
    Child's grade in school:_____

10. Has your child ever been retained? YES NO If yes, which grade?_____

11. What is your child's current school placement?
    Regular classroom ESE Gifted Other:_____

    If your child is in an ESE program, please check all that apply:
    ____Full time ____Part time ____Self contained _____Pull Out
    And in what specific type of classroom (LD, EMH, SLI, HI, VE)?_____

12. List all special education/therapy services your child is **CURRENTLY** receiving (i.e.: speech/language therapy, OT, PT, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. List all other special education/therapy services your child has **RECEIVED IN THE PAST**, but is no longer receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Has your child made progress in previous speech, language, and/or feeding therapy? YES NO
    Please explain: _____
    _____

15. How does your child react to his/her difficulties:
    At home?
    _____
    _____
    _____

    In the classroom setting?
    _____
    _____
    _____

Therapist's Notes:_____
_____
_____
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Oral Mechanism and Feeding:

1. Does your child have a history of tethered oral tissues? YES NO
   If YES:
   In what oral structures were restrictions present? (Circle all that apply)
   Upper lip Lower lip Cheek area
   Anterior tongue Posterior Tongue

   Has your child had remediation surgery for this? YES NO
   Date of surgery: _____
   Surgery completed by: _____
   Date of Follow-up:_____
   Did your doctor give you post-surgery stretches? YES NO

2. Does your child have a history of: (Circle all that apply)
   Drooling Mouth breathing loss of liquid or food when eating/drinking

3. Does your child have a history of or currently do any of the following (check all that apply):
   _____ Thumb/finger sucking At what age_____ Until what age_____
   _____ Using pacifier At what age_____ Until what age_____
   _____ Putting objects in mouth At what age_____ Until what age_____

1. Teeth brushing:
   a. Does your child brush his/her teeth independently or need your help?_____
   b. If you help them, do they enjoy having their teeth brushed?_____
   c. Do they bite down or chew on the toothbrush?_____
   d. Are they seen by a dentist? If yes, who?_____
   e. Have they had dental issues? If yes, please explain:
      _____

7. Does/Did your child have trouble with any of the following? YES NO
   Breast-feeding Bottle-feeding Baby foods Table foods
   If yes, please explain: _____

8. Would you consider your child to be a picky eater? YES NO
   If yes, please explain: _____

9. Is your child a messy eater? YES NO
   If yes, please explain: _____

10. Can your child drink from a variety of containers (open cup, straw, sippy, water bottle, etc)? YES NO
    If your child has difficulties with one of these, please list:_____

Therapist's Notes:_____
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Family Information and History:

1. Past family history of: (please check) Who?
   - ___Late talking _____
   - ___Speech/fluency problems _____
   - ___Language problems _____
   - ___Cognitive impairment _____
   - ___Learning disabilities _____
   - ___Dyslexia _____
   - ___Psychological/psychiatric problems _____
   - ___Neurological problems _____
   - ___Autism _____
   - ___Genetic disorders _____
   - ___Hearing problems _____
   - ___Other _____

2. Does anyone in your family have a history of food allergies/sensitivities? YES NO
   If yes, please list:_____
   _____

3. List all people living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Circle parents' level of education:

Mother:	Grade school	High school	College	5+
Father:	Grade school	High school	College	5+

5. Mother's current occupation/job: _____
6. Father's current occupation/job: _____

Other:

Please list any other information you feel is important for us to know:

_____
_____
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Therapist's Notes:_____
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General Consent Form:

TheraKids, Inc. may need to contact, or be contacted by, other professionals who have seen or currently see/work with your child. The need for contact may occur due to these needs:

1. Obtaining previous medical or other professional records necessary for evaluation and/or therapy.
2. Discussing your child's evaluation and /or therapy in order to address concerns, recommend additional services, referral to other professionals, and/or to discuss the child's progress.
3. Releasing copies of the evaluation report or progress notes, including documentation to insurance companies.

I hereby consent to the release of all therapeutic records (including evaluations, daily progress notes, or other documents) to the following:

Child's Name:_____ Child's Date of Birth:_____
Your Name (print):_____ Relation to Child:_____
Your Signature:_____ Date:_____
Are you the legal guardian for this child? □ Yes □No If no, name of legal guardian:_____

(Please check each box that applies and print clearly)

□ Pediatrician Name:_____ Group Name:_____
Phone:_____ Fax:_____
Address:_____

□ Other Doctor Name:_____ Specialty:_____
Phone:_____ Fax:_____
Address:_____
Name of Facility:_____

□ Other Doctor Name:_____ Specialty:_____
Phone:_____ Fax:_____
Address:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ School Name of School:_____ Teacher/Therapist Name:_____
Phone:_____ Fax:_____
Address:_____

□ Family Members Name:_____ Relation to Child:_____
Phone:_____ Email:_____
Address:_____

Name:_____ Relation to Child:_____
Phone:_____ Email:_____
Address:_____

Appointment and Daily Schedule Form

Child's Name:_____ Date of Birth_____
Your Name:_____ Relation to Child:_____

Today your child is being assessed to determine/rule-out his/her need for therapy. If your child does qualify for therapy, we will need to arrange days and times with you that would be optimal for your child to attend therapy. Although it is not always possible for us to meet these exact days and times, we do try our best to accommodate your preferences.
Below, please list **ALL** days and hours (Monday-Friday) that your child is available. Please make sure to fill this out accurately taking into account any time your child may be in school or other therapies, and may have tutoring or sports.

Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____

HIPAA – Notice of Privacy Practices

Along with this history form you were given a sheet with information regarding out privacy practices. Please fill out and sign below as confirmation that you were given this information.

I, (print name)_____, have received and read the following documents, and they were explained to me, as needed: *Notice of Privacy Practices, as required by HIPAA; Letter of introduction to TheraKids, Inc.*

_____ _____
Signature/Relation to patient **Date**

THANK YOU FOR YOUR CAREFUL ATTENTION TO THIS FORM.
This confidential information will be used to assist us in the evaluation of your child.