TheraKids INC.

Specializing in Pediatric Speech, Language, Feeding, and Swallowing

Infant Tethered Oral Tissues History Form

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:
____ Feeding/Swallowing: Child is not able to breast or botte feed; child is feeding but not efficiently; child is coughing or choking with feeds
____ Oral Motor: Child has oral ties, child may not move mouth appropriately when feeding

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

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

Therapist's Notes:_____
_____
_____
_____
_____

1325 SE 25th Loop, Suite 102 Ocala, FL 34471 Phone: 352-368-7728 Fax: 352-368-3808
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: NO YES
   Explain:_____
   _____

5. List any problems or 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. 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 ___ Runny stools ___ Rashes
   ___ Allergies: __None __Seasonal __Food __Other
   Please list all allergies, including foods:_____
   _____
   Other:_____

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

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

4. List all medications your child currently takes:

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

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

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

7. 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	_____	_____

8. With whom does your child spend his/her days? _____

9. What does your child do during the day? _____

10. List all special education/therapy services your child is **CURRENTLY** 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)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Oral Mechanism:

1. Does your child have a history of tethered oral tissues? NO YES
   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? NO YES
   Date of surgery: _____
   Surgery completed by: _____
   Date of Follow-up:_____
   Did your doctor give you post-surgery stretches? NO YES

2. Does your child have tightness on one side or torticollis?

3. Has your child been diagnosed with plagiocephaly? NO YES
   If YES, is your child receiving any intervention in this regard? Please explain: _____
   _____

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

Feeding:

1. Was/is your child breast fed? NO YES If yes, for how long? _____
   Is he/she still breast fed? NO YES If no, when did he/she stop? _____
   Reason for stopping: _____
   Problems/Difficulties: _____
   If still breast fed, _____ times a day, every _____ hours
   How long is each breast feeding session? _____
   Does your child feed better on one breast than the other? NO YES
   If yes, please explain:_____
   _____
   Do you feel like you are currently producing adequate milk for breastfeeding? NO YES
   Is/Was your child followed by a lactation consultant? NO YES

2. Was/is your child bottle fed? NO YES If yes, for how long? _____
   Is he/she still bottle fed? NO YES If no, when did he/she stop? _____
   Reason for stopping: _____
   Problems/Difficulties: _____
   Current bottle and stage nipple being used:
   _____
   _____
   If still bottle fed, please fill in the following:
   _____ times a day, _____ounces every _____ hours
   How long is each bottle feeding?_____
   What liquid is in the bottle? _____ Breast milk _____ Formula _____ Combination of breast milk and formula

3. If your child has a history of tethered oral tissues with remediation, how was feeding:
   Before remediation:_____
   _____
   After remediation:_____
   _____

Other:

1. Is your child a good sleeper? NO YES
   If no, please explain: _____
   _____

2. What would you consider to be your child's temperament? (Circle all that apply.)
   Generally happy Rarely cries Cries some throughout the day Upset all the time Cannot be consoled

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 (including milk allergies as an infant)?
   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, may have special activities, and may continue to have the need for naps.

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.