TicTalkToes
SPEECH AND OCCUPATIONAL THERAPY

New Patient Registration

Child's Name: _____ DOB: ____/____/____ ☑ Male ☑ Female

Address: _____City/State:_____ Zip:_____

Parent(s) /Guardian(s) Name(s): _____

Home Phone: _____ Cell Phone:_____

Email address:_____

Emergency Contact Name: _____ Relationship to Child: _____

Emergency Contact Phone #1:_____ Phone #2:_____

What is the best way to contact you for scheduling? ✔ Email ✔ Phone

If you have a balance due, how would you like to be billed? ✔ Email (preferred) ✔ Mail

Referred By: _____

How did you hear about TicTalkToes Therapy?_____

Prenatal and Birth History

This child is your: ☑ Biological child ☑ Adopted child ☑ Foster Child

Mother's age at child's birth: _____ Did mother receive routine prenatal care? ☑ Yes ☑ No

Length of pregnancy: _____ Birth weight: ____lbs ____oz Apgar Score _____

Type of Delivery: ☑ Cesarean ☑ Vaginal ☑ Breech ☑ Feet First

Any unusual conditions that may have affected the pregnancy or birth?

_____

_____

Medical History

Physician's Name: _____ Phone:_____

Physician's Address:_____

Other Physicians/Specialists Involved In Care:

_____

If the child is taking vitamins or medication(s), please list them:

_____

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Please list any allergies and how the reactions are managed:

_____

Has the child had any surgeries? If yes, please list the type and when it was completed:

_____

Please indicate if the child has been diagnosed with:

☑ Autism	☑ Down Syndrome	☑ Auditory Processing Disorder	☑ Developmental Delay
☑ Hearing Loss	☑ Cerebral Palsy	☑ Tongue Thrust	☑ Congential Anomaly
☑ Genetic Disorder	☑ Dispraxia	☑ Sensory Disorder	☑ Intellectual Disability

Developmental History

At what approximate age did the child do the following?:

Sit up:	Crawl:	Stand up:
Walk:	Babble:	First word(s):
Put 2 words together:	Sentences:	Tell a Story:
Use the toilet:	Ride a tricycle:	Dress self:

Language

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

How many words does the child say: _____

Please indicate the average length of words the child uses in a sentence: _____

If the child is not using words, how do they primarily communicate?

_____

Feeding History/Background

Was your child: ☑ Breastfed From when to when: _____

☑ Bottle Fed From when to when: _____

Type of bottle/nipple: _____

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Please describe any problem(s) with breastfeeding and/or bottle feeding?

_____

_____

_____

Which formulas were tried or tried first? _____

At what age did your child transition to: Baby cereal?_____ Baby food?_____

Finger foods?_____ Transition fully to table food?_____

Please describe how these transitions were handled by your child:

_____

_____

What type of formula is your child receiving now? _____

When were solid foods first introduced? _____

Does your child allow you to brush his or her teeth? ☑ Yes ☑ No

Does your child have a history of: (Check all that apply below.)

Oral: ☑ Gagging ☑ Drooling ☑ Long-term NPO

Pharyngeal: ☑ Choking ☑ Gurgly vocal quality

Respiratory: ☑ Gets sick for a long period of time ☑ Hoarse vocal quality

☑ Pneumonia ☑ Wheezing ☑ Aspiration

GI Issues: ☑ Crying after feeding ☑ Constipation ☑ Nausea ☑ Inability to gain weight

☑ Ruminating ☑ Vomiting after feeding ☑ Chronic diarrhea

Current Feeding skills

How does your child primarily feed currently?

☑ Bottle	☑ Regular Cup	☑ Sippy Cup	☑ Straw
☑ Feeds him/herself	☑ Spoon/utensils	☑ Finger foods	☑ Non Oral

What kinds of food does your child eat regularly? (check all that apply)

☑ Breastmilk	☑ Formula	☑ Thin liquids	☑ Thickened liquids

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☑ Pureed food	☑ Mashed table food	☑ Chopped table food	☑ Regular table food

On average, how many ounces does your child drink a day? _____

What liquids does your child now drink? _____

How long does it take your child to finish a meal? _____

How many snacks/meals does your child eat a day?_____

What meal does your child do best with: ☑ Breakfast ☑ Lunch ☑ Dinner

Would you describe your child's weight as: ☑ Overweight ☑ Underweight ☑ Ideal

List the foods your child will currently eat and drink, divided into 3 categories (put a star next to their favorites)

FRUIT/VEG	CARBOHYDRATES	PROTEIN

List the foods your child dislikes/avoids: _____

_____

Feeding Behaviors

☑ Gets tired easily	☑ Gags	☑ Selective/picky	☑ Refuses food offered
☑ Vomiting	☑ Turns head	☑ Difficulty breathing	☑ Cries
☑ Leaves the table	☑ Holds food in cheeks	☑ Tantrums	☑ Spits food out
☑ Loses lots of food out in front of mouth	☑ Coughs during feeding	☑ Reflux	☑ Chews but doesn't swallow
☑ Difficulty swallowing	☑ Eats too much	☑ Eats too little	☑ Throws food

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☑ Falls asleep	☑ Stiffens body	☑ Arches back	☑ Other

Please describe any other concerns you have regarding your child's behavior(s):

_____

Tube Feeding Questions (If not applicable, please skip.)

Type of feed	Aprx start date	Aprx End date	What type (continuous, bolus, combo), duration/frequency, & how much.
NG (nasogastrict tube)			
OG (oral gavage)			
NJ (nasojejunal)			
GT (gastrostomy)			
TPN (total parental nutrtion)			
JT (jejunal)			

Feeding Environment

Who usually feeds your child and what works best when feeding him/her?_____

_____

Where do you feed your child most often?

☑ Infant/booster seat ☑ Lap ☑ Highchair ☑ Wheel chair ☑ Other: _____

How is your child positioned for feeding? ☑ Sitting up ☑ Lying down ☑ On lap ☑ Other

Does your child eat with the family or does he/she eat separately? _____

During eating times, are there other activities going on in the area where your child is eating? If yes, please describe: _____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time:

_____

_____

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What are you expecting out of this evaluation / meeting?

_____

_____

Has the child had a previous feeding evaluation / treatment? ☑ Yes ☑ No

By whom: _____ When: _____

Describe the results:

_____

_____

At what age did you first notice the problem? _____

How does the child's feeding difficulties impact the family?

_____

Educational History

School: _____ Grade _____

Teacher(s): _____

Has an IEP or IFSP been developed for the child? If yes, please include the date of the last written IFSP/IEP: _____

Does your child receive special services? If yes, please describe:

_____

_____

Please provide any other additional information that might be helpful in the evaluation (e.g. their likes or dislikes, their behavior, strategies you might use to help them…etc) and any goals that you would like your child to focus on:

_____

_____

Person completing form: _____

Relationship to Child _____ Date: _____

THANK YOU FOR COMPLETING THIS FORM!

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