Advanced Speech & Language Associates, LLC

Confidential Patient Intake Form

Medical History

Patient Name: Today's Date:

DOB: Medical Diagnosis:

Birth History:

Was this child premature?	Yes	No
Was the mother's health poor during pregnancy?	Yes	No
Did the mother experience any illness, abnormal condition or accident during pregnancy?	Yes	No
Did this child experience any trauma at birth or during birth?	Yes	No
Did this child have lack of oxygen at birth?	Yes	No
Was this child low birth weight?	Yes	No
Was this child's health poor at birth?	Yes	No
Did this child remain in the hospital after birth (more than 2 days)?	Yes	No
Did this mother have little to no preterm care during pregnancy?	Yes	No
Did the mother use any cigarettes, alcohol or drugs during pregnancy?	Yes	No

Please explain "yes" answers:

Please circle all apply, presently and past:

Medical Problem	Age and Severity	Medical Problem	Age and Severity
Ear Infections		Cardio (heart) surgery	
High Fevers		Allergies	
Tonsillectomy		Adenoidectomy	
Cleft Palate		Asthma	
Measles, Mumps or Rubella		Pneumonia	
Chicken Pox		Injuries/Falls	
Ear Tubes		Meningitis	
Bumps to the head		Paralysis	

Does this child have any known allergies? To what:____________________	Yes	No
Does this child take any medication (Rx or herbal/vitamin) ____________________	Yes	No
Does this child have a restricted diet? ____________________	Yes	No
Does this child appear healthy , most of the time?	Yes	No
Has this child been seen by a neurologist? Date:_______ Were the results normal?	Yes	No
Has this child been seen by a psychologist? Date:_______ Were the results normal?	Yes	No
Has this child had a hearing assessment? Date:_______________ Were the results normal?	Yes	No
Has this child had a vision assessment? Date:_______________ Were the results normal?	Yes	No

Please explain other medical information that we may find helpful when treating your child: