Shoreline
Speech & Language Center

2200 Pacific Coast Hwy, Ste 210
Hermosa Beach, CA 90254
T: (310) 740-9493
F: (310) 469-7848
info@shorelinespeech.com

FEEDING AND SWALLOWING
PATIENT REGISTRATION FORM

Today's Date_____

PATIENT INFORMATION

PATIENT NAME: _____ SEX:_____ DOB: ____-____-_____
LAST FIRST MI M/F MO DAY YEAR
HOME PHONE: _____ SS#: _____-_____-_____
ADDRESS: _____ CITY:_____ STATE: _____ZIP: _____
REFERRING PHYSICIAN: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN:_____ PHONE NUMBER: _____

PRECAUTIONS/ALLERGIES: LIST FOOD ALLERGIES: _____
LATEX ALLERGY: Y or N HAS SEIZURES: Y or N LIST ALL OTHER ALLERGIES:
_____

RESPONSIBLE PARTY (PARENTS/LEGAL GUARDIANS)

FATHER'S NAME: _____ DOB: _____-_____-_____
LAST FIRST MI MO DAY YEAR
EMPLOYER: _____ OCCUPATION:_____
BUSINESS ADDRESS: _____ CITY:_____ STATE: _____ZIP: _____
BUSINESS PHONE: _____ CELL PHONE: _____
E-MAIL ADDRESS: _____
PREFERRED METHOD OF COMMUNICATION: HOME ____ WORK ____ CELL ____ E-MAIL ____

MOTHER'S NAME: _____ DOB: _____-_____-_____
LAST FIRST MI MO DAY YEAR
EMPLOYER: _____ OCCUPATION:_____
BUSINESS ADDRESS: _____ CITY:_____ STATE: _____ZIP: _____
BUSINESS PHONE: _____ CELL PHONE: _____
E-MAIL ADDRESS: _____
PREFERRED METHOD OF COMMUNICATION: HOME ____ WORK ____ CELL ____ E-MAIL ____

INSURANCE

PRIMARY INSURANCE: _____ POLICY NUMBERS: _____
(ID#) (GROUP/PLAN)
POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI
DOB: ____-____-_____ SS#: _____-_____-_____ RELATION TO PATIENT _____
MO DAY YEAR
INSURANCE PHONE: _____ COPAY AMOUNT: _____
SECONDARY INSURANCE: _____ POLICY NUMBERS: _____
(ID#) (GROUP/PLAN)
POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI
DOB: ____-____-_____ SS#: _____-_____-_____ RELATION TO PATIENT _____
MO DAY YEAR
INSURANCE PHONE: _____ COPAY AMOUNT: _____

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RELEASE OF INFORMATION

I authorize the exchange of protected health information between Shoreline Speech & Language Center and the specified individuals below:

PRIMARY DOCTOR/CLINIC: _____ PHONE: _____
SPECIALTY DOCTOR/CLINIC: _____ PHONE: _____
_____ PHONE: _____
PRESCHOOL/SCHOOL DISTRICT: _____ PHONE: _____
SOCIAL WORKER: _____ PHONE: _____
OTHER: _____ PHONE: _____
_____ PHONE: _____

OTHER CONTACTS

Please list other individuals who are involved in taking care of the patient, such as a caregiver and/or relative other than a guardian, with whom you authorize **Shoreline Speech & Language Center** to discuss/exchange information regarding the patient's treatment:

NAME: _____ RELATION TO PATIENT: _____
HOME PHONE: _____ CELL PHONE: _____
NAME: _____ RELATION TO PATIENT: _____
HOME PHONE: _____ CELL PHONE: _____

Shoreline Speech & Language Center occasionally videotapes/photographs for lecture, training, webpage, and/or marketing. I give Shoreline Speech & Language Center permission to photograph/videotape my child for the following purposes:

PROFESSIONAL LECTURE/TRAINING YES NO
WEBPAGE YES NO MARKETING MATERIALS YES NO

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

1. I have received the Notice of Privacy Practices from Shoreline Speech & Language Center.
2. I have received the Patient Services Agreement from Shoreline Speech & Language Center.
3. I understand that I am under contract with Shoreline Speech & Language Center.

SIGNATURE: _____ DATE: _____
PARENT/LEGAL GUARDIAN

I hereby authorize Shoreline Speech & Language Center to furnish information concerning treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS, and/or OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to Shoreline Speech & Language Center. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENTS OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: _____ DATE: _____
PARENT/LEGAL GUARDIAN

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OTHER PERSONS LIVING IN THE CHILD'S HOUSEHOLD:

NAME	AGE	RELATIONSHIP TO CHILD	LEARNING OR DEVELOPMENT PROBLEMS?

WHAT LANGUAGE(S) IS/ARE SPOKEN AT HOME? _____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

NAME: _____ _____
ADDRESS: _____
PHONE#: _____ WHEN IS CHILD IN THIS CHILDCARE? _____

BIRTH HISTORY (FOR THE CHILD BEING EVALUATED):
HOSPITAL WHERE BORN (CITY & STATE): _____
PHYSICIAN'S NAME: _____
GESTATIONAL AGE AT TIME OF DELIVERY (OR # OF WEEKS EARLY OR LATE): _____
LENGTH OF LABOR (IN HOURS): _____
TYPE OF LABOR STIMULATION AND WHAT WAS USED: _____

Please list any type of pain medication or anesthesia used during delivery:
_____
_____

WHAT TYPE OF DELIVERY (PLEASE CIRCLE):
VAGINAL CESAREAN SECTION ~ ELECTIVE OR EMERGENCY
REASON FOR C-SECTION: _____

PRESENTATION (PLEASE CIRCLE): HEAD FIRST FEET FIRST BREECHTRANSVERSE

ASSISTANCE: FORCEPS, VACCUUM, OTHER _____

Were there any unusual conditions that may have affected the pregnancy or birth?
_____
_____
_____
_____

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PRENATAL AND BIRTH HISTORY

Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc.):

YES	NO	DESCRIPTION	EXPLANATION
		Maternal Infection	
		Low/High red/white blood cell count	
		Pelvis or cervical problems	
		Placenta problems	
		Dysfunctional labor	
		Baby had the cord around the neck	
		Cord problems (knots, prolapsed, compression)	
		Baby had very low or high heart rate	
		Baby had heart rate decelerations	
		Fetal distress was noted	
		Meconium was noted	

How soon after the delivery did you see your baby _____

What were the baby's APGAR scores? 1 minute _____ 5 minutes _____

What was the baby's Birth Weight? _____ Birth Length _____

Number of Days spent in the nursery? _____ NICU or Newborn Nursery? _____

What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc.):

YES	NO	DESCRIPTION	EXPLANATION
		Was blue/cyanotic at birth	
		Required stimulation to breathe	
		Required oxygen at birth	How much/what type?
		Required resuscitation	
		Was considered small for gestational age	
		Had tremors or seizures	Which/for how long?
		Very low tone	
		Brain hemorrhage	
		Anemia and/or transfusions	Which/how many times?
		Jaundice (yellow)	How much/how treated?
		Had bruising	
		Rh incompatibility problems	
		Infections	

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		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/how treated?
		Respiratory distress signs or syndrome	

(cont.) What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc.):

YES	NO	DESCRIPTION	EXPLANATION
		Needed ventilation	What type/how long?
		Choking or vomiting episodes	
		Tube feedings	
		Needed medications	

MEDICAL HISTORY OF CHILD

IT IS VERY IMPORTANT TO HAVE AS COMPLETE A MEDICAL HISTORY FOR YOUR CHILD AS POSSIBLE. PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

DESCRIPTION	YES	NO	DESCRIPTION	YES	NO
Frequent Colds/Respiratory Illness			Visual disorder/vision problems		
Frequent Strep throat/sore throat			Eye infections		
Frequent Ear Infections (?tubes)			Neurological disorder		
Birth defect/genetic disorder			Seizures or convulsions		
Lung condition/respiratory disorder			Stomach disorder/stomach pain		
Allergies or asthma			Vomiting/digestion problems		
Heart condition			Failure to gain weight/feeding problems		
Anemia/blood disorder			Constipation/diarrhea problems		
Kidney/Renal disorder			Dehydration episodes		
Urinary problems/infections			Hearing Loss/Ear disorder		
Hormonal problem			Significant accidents		
Muscle disorder/muscle problem			Head injuries or concussions		
Joint or bone problems			Ingestion of toxins, poisons, foreign objects		
Fractured bones			Major medical procedures (detail below)		
Skin disorder/skin problems (eczema)			Chronic medications (for what? when?)		
Any major childhood illness (pox, croup, measles, mumps, meningitis etc)					

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE AN EXPLANATION. IN YOUR EXPLANATION, PLEASE INCLUDE YOUR CHILD'S AGE(S) IF RELEVANT, ANY DIAGNOSES MADE, AND ANY TREATMENTS THAT OCCURRED:

_____

_____

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_____
_____

HOSPITALIZATIONS AND/OR SURGERIES:

LIST THE DATES OF ANY HOSPITALIZATIONS AND OR SURGERIES YOUR CHILD HAS HAD AND THE REASONS.

1. _____
2. _____
3. _____
4. _____

MOST RECENT HEIGHT: _____ WEIGHT: _____ DATE: _____

PLEASE NOTE ANY ILLNESSES FOR WHICH YOUR CHILD IS CURRENTLY BEING TREATED:

_____
_____

CURRENT MEDICATIONS:

MEDICATION	PRESCRIBED BY	DOSE	REASON PRESCRIBED

ORAL MOTOR DEVELOPMENT AND FEEDING HISTORY

Has your child had any feeding difficulties? Check each item that applies.

_____ Sucking or nursing
_____ Excessive length of time to drink bottle
_____ Regurgitation of liquids or solids through the nose
_____ Difficulty chewing or swallowing meats
_____ Gagging

Does your child drool more than other children his/her age? _____ Yes _____ No

Did your child have difficulty gaining weight as an infant? _____ Yes _____ No

Does/Did your child use a pacifier? _____ Yes _____ No

Does/Did your child suck their thumb? _____ Yes _____ No

Does your child currently choke while eating? ____Yes ____No
If "yes", on what foods? _____
_____
_____

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Is your child a picky eater? ____Yes ____No
If "yes", what food does he/she prefer? _____
_____
_____

Describe feeding problems your child has experienced or is currently experiencing:
_____
_____
_____
_____

Describe what you have done to help your child at mealtimes:
_____
_____
_____
_____

Who is your child's primary feeder: _____

DEVELOPMENTAL HISTORY

WE WOULD LIKE TO HAVE INFORMATION ABOUT YOUR CHILD'S DEVELOPMENTAL MILESTONES. PLEASE MARK WHETHER YOU BELIEVE YOUR CHILD ACCOMPLISHED THE MILESTONE EARLY, ON TIME, OR LATE. IF YOR CHILD HAS NOT YET ACHIEVED THE MILESTONE, PLEASE WRITE N/A.

MILESTONE	EARLY	LATE	ON TIME	MILESTONE	EARLY	LATE	ON TIME
Held Head Up (1-3 months)				Transferred Object Between Hands (6-8 months)			
Smiled (2-4 months)				Stood Alone (10-12 months)			
Rolled Over (3-6 months)				Walked by self (12-15 months)			
Reach/Grasp (4-6 months)				Ate unaided w/spoon or fork (12-15 months)			
Sat Unsupported (6-7 months)				Dressed self (24-36 months)			
Crawled (6-8 months)				Potty trained (days) (24-36 months)			

DO YOU FEEL YOUR CHILD WAS "FASTER" OR "SLOWER" THAN HIS/HER PEERS IN ANY OTHER WAY? PLEASE EXPLAIN: _____
_____

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EDUCATIONAL HISTORY

NAME OF CURRENT SCHOOL: _____ GRADE: _____

ADDRESS: _____ PHONE: _____

HOURS CHILD ATTENDS SCHOOL: _____

TEACHER: _____

ANY SPECIAL EDUCATION SERVICES (WHICH/WHEN)? _____

DESCRIBE ANY CONCERNS SHARED BY THE TEACHER: _____

_____

_____

PREVIOUSLY ATTENDED SCHOOL(S):

NAME: _____ GRADE: _____

THERAPY HISTORY

HAS YOUR CHILD EVER BEEN EVALUATED FOR OR ATTENDED THERAPY FOR:

SPEECH PROBLEMS _____ VISION PROBLEMS _____ FEEDING PROBLEMS _____

HEARING PROBLEMS _____ PHYSICAL MOTOR PROBLEMS _____

OTHER _____

PLEASE GIVE LOCATIONS, DATES, AND RESULTS: _____

WHAT OTHER SERVICES DOES YOUR CHILD CURRENT RECEIVE? WHAT HAS HE/SHE RECEIVED PREVIOUSLY?

TYPE OF SERVICE	CURRENT	PREVIOUSLY
PHYSICAL THERAPY		
OCCUPATIONAL THERAPY		
SPEECH-LANGUAGE THERAPY		
BEHAVIORAL THERAPY		
NUTRITIONAL SERVICES		

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FEEDING/SWALLOWING THERAPY		
OTHER (PLEASE DESCRIBE)		

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.