Core Communication Center

Pediatric and Adult Speech Therapy

ID # _____

Intake Form - Child

Current Date:

Patient Information

Male Female

Last Name: First Name: **Birth Date**:

Address *(residence)*: Apt. #: Address *(mailing)*:

City: State: Zip:

Parent Name: Relationship: Phone:

Parent Name: Relationship: Phone:

Email: cell home work

Primary Care Physician: PCP Office:

Referral Information

Referred by: Phone:

Relationship to patient:

Health History

Medical Diagnosis:

Operations, Accidents, Illnesses:

Allergies:

Medication List: *Please list medications and what they are f*

222 Tuckerman Road, Ashburnham, MA 01430
Phone: (978) 833-1887 ***Fax:*** (978) 252-5218
CoreCommunciationCenter@gmail.com

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Birth History:

Place of Birth (City, State):

Length of Pregnancy (weeks):

Birth Weight: (Lbs., Oz.):

In NICU? Yes No Number of Days: Reason:

Pass Newborn Hearing Screening: Yes No Retested: Yes No (results):

Concerns or complications at birth:

Immunizations Current? Yes No (please explain):

Does your child have Reflux: Yes No Taking Reflux Medication?: Yes No

Name of Medication *(if any)*:

HA's:

Do you have concerns for Hearing? Yes No Audiological Consult (date/results):

Do you have concerns for Vision? Yes No Opthamologist Consult: (date/results):

Glasses:

Daycare Provider (if any):

EI Program, School, other:

Please List all other Medical Professionals following your child.

Hospital/Facility:	*List all Departments:*	*Reason (be brief):*

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How Can We Help

Has child ever received Speech Therapy? ○ Yes ○ No

Where: _____ When: _____

Reason: _____

Please describe why you are here today, and what your concerns are.

How can we help you?

Office Use Only Initial Contact _____

Diagnosis Code: _____

_____

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