Desoto Family Counseling
& Pediatric Therapy Center

FINDING SILVER LININGS SINCE 2001

8626 AIRWAYS BLVD
SOUTHAVEN, MS 38671
PHONE: 662.772.5937
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BASIC IDENTITY & CONTACT INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

Parent/Legal Guardian's Name: ____

Address: ____

Phone Number(s): ____

BACKGROUND INFORMATION

Language spoken in home: ______________________ Current School/Daycare: __________________

Current Grade: ____________ Number of Siblings & Ages: ________________________________

Concerns regarding performance at school or daycare: ______________________________________

____

BIRTH HISTORY

Weight: ________ Length: ________ Type of delivery: ______________________________

Was there anything unusual about the pregnancy or birth? Please describe. _________________________

____

How old was the mother at birth? ________Was the mother sick during pregnancy? Please describe. __________

____

How long was the baby's hospital stay after birth? _______________________________________

Did the baby receive any medication or treatment during the hospital stay? Please describe. ______________

____

MEDICAL HISTORY

Is the child currently taking any medications? Please describe. ____

____

Please describe any diagnosis the child has received from a physician or therapist. ______________________________

____

Please list any surgeries: ____

Please list any other serious injuries: ____

Is the child currently (or recently) under a physician's care for a condition? Please describe. ___________________________

____

Has your child's hearing been tested recently? Please provide the date and results. ______________________________

____

DEVELOPMENTAL HISTORY

Please give the approximate age your child achieved the following developmental milestones:

__________Sat Alone __________Babbled __________Crawl __________Said their 1st word

__________Walked __________Put 2 words together

SPEECH & LANGUAGE HISTORY

Describe any speech and/or language problem. ____

____

____

When was the problem first noticed? ____

____

Has the problem become better or worse? Please describe. ____

____

Have you received any speech therapy or other treatment? Please describe the treatment and results. ________________________

____

____

Is there a family history of speech and/or language delays? Please describe. ____

____

SWALLOWING

Current diet: ____

What utensils/devices/cups/etc are being utilized during feedings? ____

____

How often are feedings? __________________________ Current weight: _____________ Current Height: _____________________

Any difficulty gaining/maintaining weight? Please describe. ____

____

Any gastrointestinal issues? Please describe. ____

____

Describe any swallowing problem below. ____

____

When was the problem first noticed? ____

Has the problem become better or worse? Please describe. ____

____

Is there any other information that is pertinent to this evaluation? ____

____

HOME EXERCISE PROGRAM

In order to better serve your child and ensure continuation of care is being followed through with the home setting, the following Home Exercise Program (HEP) guidelines are to be complied with in the home setting. Failure to follow through with the HEP as directed by the clinician will demonstrate non-compliance with the plan of care established for your child and will result in termination of service for your child with Desoto Family Counseling & Pediatric Therapy Center. For concerns, questions, or clarification of HEP expectations, please speak with your child's clinician.

I, the parent or legal guardian signed below, agree to follow through with the HEP as directed by my child's therapist in the home setting 5 out of 7 days of the week and agree to bring necessary items (communication device, walker, splint, food items, etc) for my child to therapy consistently.

I, the parent or legal guardian signed below, understand I am responsible for providing consistent carryover of skills gained/learned/attempted in therapy in order to make an effective change in my child.

I, the parent or legal guardian signed below, agree to complete necessary tasks within the home environment as directed by my child's clinician and provide verification of compliance as needed.

I, the parent or legal guardian signed below, understand my child can have their services terminated with continued non-compliance with established HEP.

Patient Printed Full Name: ____

____
Parent/Legal Guardian Signature & Today's Date

____
Clinician Signature & Today's Date