ADVANCE
— for kids —
PEDIATRIC
Physical, Occupational,
and Speech-Language Therapy

Child's Name: _____ Birthdate: _____ Age: ____ SS#:_____

Sex: □ M □ F Address: _____ City: _____ State: _____

Zip: _____ Primary Phone #: _____ Alternate Phone #:_____

Email address: _____ Emergency Contact: _____ Phone #: _____

Diagnosis/ Reason of Referral: _____ Pediatrician/Primary Care Physician: _____

Family Information

Mother/caregiver name: _____

Father/caregiver name: _____

Please list ***all other members currently living*** in household:

Name	Age	Relationship to patient	Any disabilities/deficits
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother/caregiver occupation: _____

Father/caregiver occupation: _____

Marital Status of parents/caregivers: □ Married □ Single □ Separated □ Divorced □ Widowed

Primary language spoken in the home: □ English □ Spanish □ Other _____

Pregnancy/Birth Information

List any complications during pregnancy (including accidents, high blood pressure, required medication, etc.):

_____

_____

Was tobacco, alcohol, or drugs used during the pregnancy? □ yes □ no If yes, please describe_____

_____

List any complications during the birth process (including if delivery was breeched, C -section, if forceps were necessary, prematurity, etc.) _____

_____

_____

Birth weight: _____lb. _____oz. If premature, how many day/weeks? _____

Did the baby spend time in the Neonatal Intensive Care Unit (NICU)? □ yes □ no How long?_____List any complications noted after birth (including need for oxygen, jaundice, deformities, feeding difficulties, etc.)

_____

_____

Did the baby require an extended hospital stay after birth? □ yes □ no If yes, how long?_____

Medical/Health Information

List all current medications:

Name of medication, dosage, and reason for taking medication

1) _____
2) _____
3) _____
4) _____

Please check all conditions your child has experienced:

□ Adenoidectomy	□ Ear Surgery	□ Snoring
□ Asthma	□ Ear Tubes	□ Tonsillectomy
□ Breaths with mouth open during day/ night	□ Frequent fevers	□ Tracheotomy
□ Bronchitis	□ Frequent colds	□ Meningitis
□ Bronchopulmonary dysplasia	□ Frequent pneumonia	□ Mumps
□ Cerebral Hemorrhage	□ Frequent sinus infections	□ Myelomeningocele
□ Cleft lip or palate	□ Head injury	□ Reflux
□ Coughing/choking during feeding	□ Heart problems	□ Seizures
□ Craniofacial deformities	□ Hoarse voice	□ Soft Voice
□ Ear Infections	□ Loud Voice	□ Vocal Nodules

List all significant illnesses, hospitalizations, and/or procedures with ***dates and locations*** (including surgery, MRI, swallow study, and other special testing)

1) _____
2) _____
3) _____

Describe any other medical problems (allergies, precautions): _____
_____
_____

Has the child received therapy previously? □ yes □ no If yes, please list:

	Type of therapy (OT, PT, ST)	**Dates started/stopped**	**Location/facility**
1)			
2)			
3)			

What school/daycare has the child participated in?

	Name of school/daycare	**Dates attended**	**Hours**	**Grades (regular or special education)**
1)				
2)				
3)				

List any other concerns or comments: _____
_____
_____
_____
_____

******MY CHILD HAS AN □ IEP (from school) □ IFSP (from Babies Can't Wait)**
If YES, Advance for Kids needs a copy for insurance purposes

_____ _____ _____
Name of parent or guardian **Relationship to child** **Date**

_____
Signature