Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

Speech, Language and Hearing Intake

Patient Information

Patient Name: _____ Date of Birth:_____

Additional Background Information

Are there any religious or cultural considerations/barriers regarding this evaluation or potential treatment?

◯ Yes ◯ No If yes, explain: _____

Have any family members had any speech, language, hearing, physical, emotional, or learning difficulties?

◯ Yes ◯ No If yes, describe: _____

_____

Has your child experienced any of the following? (Please check all that apply.)

☐ High lead levels ☐ Mouth Breathing ☐ Snoring ☐ Sleep difficulties

☐ Allergies ☐ Vision Problems If yes, explain: _____

_____

Hearing History

Did the child pass the Newborn Hearing Screening at birth? ◯ Passed ◯ Failed

Has the child's hearing been screened/tested since birth? ◯ Yes ◯ No If yes, when and where:_____

Results of the hearing test: ◯ Hearing within normal limits ◯ Hearing loss ◯ Further testing required

If your child has hearing loss, please elaborate: _____

Does your child wear hearing aids? ◯ Yes ◯ No

Has your child had a history of frequent ear infections? ◯ Yes ◯ No

PE Tubes? ◯ Yes ◯ No If yes, date of insertion: _____

If hearing was tested elsewhere, please bring a copy of the hearing test results to your appointment.

Communication

How does your child usually communicate? (Please check all that apply.)

☐ Gestures (reaching, pulling an adult, pointing, other) ☐ Visual Gaze ☐ Facial Expressions

☐ Sounds ☐ Screaming/crying ☐ Pictures ☐ AAC-Specific program or device: _____

Is your child's speech different than the rest of your family? ◯ Yes ◯ No

Is your child's speech difficult to understand? ◯ Yes ◯ No

Does your child get frustrated when attempting to communicate? ◯ Yes ◯ No

Is your child aware of his/her speaking difficulties? ◯ Yes ◯ No

Is your child able to clarify a message if not understood? ◯ Yes ◯ No

Is your child able to imitate (gestures/sounds/words/sentences)? ◯ Yes ◯ No

Is your child's speech regressing (have they lost skills)? ◯ Yes ◯ No

Is your child able to express yes and no? ◯ Yes ◯ No If yes, explain how: _____

_____

Does your child communicate differently in school/home/community settings? ◯ Yes ◯ No

Is your child able to understand what is being said to him/her? ◯ Yes ◯ No

Does your child point to things or pictures when asked? ◯ Yes ◯ No

Is your child able to follow simple 1-step directions? ◯ Yes ◯ No

Is your child able to follow complex directions (two-step or multi-step)? ◯ Yes ◯ No
Is your child able to understand conversation? ◯ Yes ◯ No
Is your child able to speak fluently without stuttering? ◯ Yes ◯ No
Does your child have difficulty paying attention? ◯ Yes ◯ No
Is your child able to stick with and complete a task? ◯ Yes ◯ No
Is your child continuously in motion? ◯ Yes ◯ No
Does your child play and socialize with peers and others? ◯ Yes ◯ No
Does your child understand humor? ◯ Yes ◯ No

Oral/Motor Feeding

How is/was your child fed as an infant: ◯ Breastfeeding ◯ Bottle feeding (formula) ◯ Both ◯ Other
If other, please explain: _____

Did the child have feeding difficulties during infancy? ◯ Yes ◯ No If yes, describe: _____
_____

Did the child have difficulties transitioning to solid foods/various textures? ◯ Yes ◯ No If yes, describe: _____
_____

Does your child have a limited diet, i.e., "picky eater"? ◯ Yes ◯ No If yes: describe _____
_____
_____

Does the child have difficulties (check all that apply):
☐ Chewing ☐ Swallowing ☐ Sucking ☐ Eating ☐ Drinking ☐ Drooling

Has your child been identified with any of the following? (Please check all that apply.)
☐ Enlarged tonsils ☐ Enlarged adenoids ☐ Tongue tie ☐ Lip tie
☐ Malocclusion or other dental concerns ☐ Cleft palate ☐ Cleft Lip

How would you describe your child's personality and specific interests? _____
_____

Please share any additional information you would like us to know about your child: _____
_____
_____

What are your goals for therapy? _____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

Relationship to patient: _____