Infant Intake Form

1. Demographic Information

Gender: ☐Male ☐Female

Client's Name:_____ **Birth Date:**____/____/____

First **Last** **MI** **Month** **Day** **Year**

Home Address:_____ Daycare:_____

Primary Caregiver's Name: _____ Relationship to client:_____

Phone Number:_____ Email Address: _____

Are text messages OK at this #: ☐Yes ☐No

Secondary Caregiver's Name: _____ Relationship to client:_____

Phone Number:_____ Email Address: _____

Are text messages OK at this #: ☐Yes ☐No

Client's Pediatrician Name: _____ Pediatrician's Phone: _____

Primary Insurance: _____ Policy Number: _____

Primary Language: _____ Secondary Language: _____

Who does the client live with?

- ☐ Mother
- ☐ Father
- ☐ Grandparent(s)
- ☐ Older Sibling(s)
- ☐ Younger Sibling(s)
- ☐ Twin Sibling(s)
- ☐ Aunt/Uncle(s)
- ☐ Other:

Does the client attend daycare?

☐No ☐Yes If yes, where do they attend? _____ Class:_____

Days/Hours they attend:_____

Has the client been to his/her pediatrician?

☐Yes ☐ No. When is the appointment scheduled?_____

Has the client been seen by any specialist, doctor, or therapist for feeding concerns?

☐No ☐Yes. If yes, please specify: _____

2. Prenatal History

Were there any prenatal complications?

- ☐ Polyhydramnios (high amniotic fluid)
- ☐ Oligohydramnios (low amniotic fluid)
- ☐ Cervical Cerclage
- ☐ Atypical positioning
- ☐ Breech position
- ☐ HELLP syndrome
- ☐ Preeclampsia
- ☐ Controlled substance/alcohol abuse
- ☐ Intrauterine growth restriction
- ☐ Large for gestational age
- ☐ Small for gestational age
- ☐ Gastroschisis
- ☐ Gestational diabetes
- ☐ Multiples: _____
- ☐ Other: _____
- ☐ Unknown

Did the client's mother receive prenatal care?

☐Yes ☐No. Reason: _____ ☐Unknown

Was the client's mother placed on bed rest?

☐No ☐Yes. Please specify: _____ ☐Unknown

Did the client move positions frequently in-utero?

☐No ☐Yes. Please specify: _____ ☐Unknown

3. Birth History

How many weeks gestation was the client born?_____weeks ☐Unknown

What was the client's birth weight? _____,_____ ☐Unknown
Pounds **Ounces**

How was the client delivered? ☐ Vaginal Delivery ☐Cesarean Section ☐Unknown

Were there any birth complications?

- ☐ Assisted delivery
- ☐ Jaundice
- ☐ Intubation
- ☐ Prolonged labor
- ☐ Low APGAR score
- ☐ Hypoxia
- ☐ Nuchal Cord
- ☐ Other: _____

Did the mother experience any complications during or after birth?

- ☐ Hemorrhaging
- ☐ Low blood pressure
- ☐ Infection
- ☐ Preeclampsia
- ☐ High blood pressure
- ☐ Other: _____

4. Postnatal History

Did the client spend any time in the NICU?

☐No ☐Yes. Please specify: _____ ☐Unknown

Did the client receive any treatments after birth?

☐No ☐Yes. Please specify: _____ ☐Unknown

Did the client experience any of the following after birth?

- ☐ Fracture
- ☐ RSV
- ☐ Infection
- ☐ Difficulty breathing
- ☐ Low glucose levels
- ☐ Other: _____

5. Medical History

Has the client ever been diagnosed with a medical condition, syndrome, or disorder?

☐No ☐Yes. Please specify: _____ ☐Unknown

Has the client ever been diagnosed with tongue, lip or cheek ties?

☐No ☐Yes. Please specify type and if released: _____

Does the client have any allergies (specifically to food or latex)?

☐No ☐Yes. Please specify: _____ ☐Unknown

Is the client up-to-date on their vaccines?

☐No ☐Yes ☐Unknown

Is the client currently taking any medications?

☐No ☐Yes. Please specify the type(s) and what it is taken for: _____

_____

Did the client pass the newborn hearing screening?

☐Yes ☐No. When is follow-up test? _____☐Unknown

Does the client have reflux?

☐No ☐Yes. Please specify how it is currently being treated: _____

Does the client currently have any of the following?

- ☐ Ear infection
- ☐ Nausea/vomiting
- ☐ Recent surgery
- ☐ Staph infection
- ☐ Hemophilia
- ☐ Swollen joints
- ☐ Diarrhea
- ☐ Malignant cysts
- ☐ Tracheostomy
- ☐ Jaundice
- ☐ Torticollis
- ☐ Plagiocephaly
- ☐ Reflux
- ☐ Distention of abdomen
- ☐ Caput succedaneum

6. Developmental History

Does the client have any delays with the following skills?

- ☐ Turning head to both sides
- ☐ Rolling
- ☐ Pushing up on all fours
- ☐ Cooing
- ☐ Grabbing toys
- ☐ Holding bottle/breast
- ☐ Mouthing toys/objects
- ☐ Babbling
- ☐ Lifting head while on tummy
- ☐ Smiling at people
- ☐ Looking at someone speaking
- ☐ Other: _____

How often does the client spend time on their tummy?

- ☐ None
- ☐ Several hours per day
- ☐ Every few days
- ☐ A few minutes per day
- ☐ Always when awake
- ☐ Unknown
- ☐ A few hours per day
- ☐ Sleeps on tummy
- ☐ Other: _____

Where the client sleep?

- ☐ Crib/Bassinet in own room
- ☐ Co-sleeper on parent's bed
- ☐ Swing or MamaRoo
- ☐ Car seat
- ☐ Crib/bassinet in parent's room
- ☐ Co-sleep with parent in bed
- ☐ SNOO
- ☐ Other: _____

Is the client colicky or difficult to console?

☐No ☐Yes. Please specify: _____

7. Feeding History

How was the client first fed?

- ☐ Breastfed
- ☐ Bottle fed
- ☐ NG tube fed
- ☐ Syringe fed
- ☐ Cup fed
- ☐ Other: _____

Was breastfeeding attempted after birth?

☐No ☐Yes. Please specify: _____ ☐Unknown

How is the client currently fed? (check all that apply)

- ☐ Breastfed
- ☐ Bottle fed
- ☐ Tube fed. Type: _____
- ☐ Syringe fed
- ☐ Cup fed
- ☐ Other: _____

What is the client currently experiencing with feeding?

- ☐ Coughing/choking when feeding
- ☐ Difficulty latching to the breast
- ☐ Difficulty removing milk from the breast
- ☐ Difficulty accepting breast (prefers bottle)
- ☐ Difficulty latching to bottle
- ☐ Difficulty removing milk from the bottle
- ☐ Difficulty accepting bottle (prefers breast)
- ☐ Maternal pain during breastfeeding
- ☐ Risk of aspiration
- ☐ Unable to accept feedings by mouth
- ☐ Vomiting during/after feeding
- ☐ Reflux symptoms
- ☐ Difficulty coordinating suck-swallow-breathe
- ☐ Aversive to feedings
- ☐ Crying before/during feeding
- ☐ Other: _____

What is the average amount of times the client is fed per day?

☐ On demand ☐ 4-6 times ☐ 7-9 times
☐ 10-12 times ☐ 9-12 times ☐ Other: _____

What is the average length of time per feeding?

☐ 5-10 minutes ☐ 10-15 minutes ☐ 15-20 minutes
☐ 20-30 minutes ☐ 30-45 minutes ☐ Other: _____

What is the average amount the client consumes during each feeding?

☐ Less than 1 ounce ☐ 1-2 ounces ☐ 3-4 ounces
☐ 5-6 ounces ☐ More than 6 ounces ☐ Other: _____

Has the client ever received a swallow study?

☐ No ☐Yes. Please specify results: _____

Does the client use a pacifier?

☐ No ☐Yes. Please specify type: _____

About how many wet diapers does the client have in 24 hours?

☐ 6 or more ☐ 4-6 ☐ 2-4
☐ 0-2 ☐ Iconsistent ☐ Other: _____

About how many stooled diapers does the client have in 24 hours?

☐ 3 or more ☐ 2 ☐ 1
☐ Less than 1 ☐ Inconsistent ☐ Other: _____

What does the client's stool typically look like?

☐ Yellow curds ☐ Green/brown slimy ☐ Tar Black
☐ Bloody/Dark ☐ Inconsistent ☐ Other: _____

Please write below anything else you would like to share with us about the client:

Thank you for taking the time to fill out this intake form. All personal information collected by Sunny Speech Inc. (DBA Sunny Pediatric Services) for the purposes of providing services, assessing client needs and referring to services. Contact the (850) 909-5521 or office@sunnyspeech.com if you have questions about the use of your personal information.