

8913 Mid Cities Blvd. Suite 100 North Richland Hills, Texas 76182 O: 817-514-6271 F: 888-920-1201

## **DiagnosTEX Pediatric Intake Form**

Patient Name:		Date of Bi	rth:
Parent(s)/Legal Guardian(s) Na	ame(s):		
Phone:	Email address:		
Language(s) Spoke in the Hom	e:	Attend daycare,	′school: ☐ Yes ☐ No
Parents' Main Feeding Concer	ns:		
Pediatrician:		Name of Office:	
Birth History			
☐ Full-term		NICU stay: $\square$ No $\square$ Yes, Lengt	h of stay
☐ Pre-term:we	eksdays	Delivery: ☐ Vaginal ☐ C-Sect	ion
Complications: $\square$ N/	Α		
Currently on Reflux Medicatio	ns: 🗆 Yes 🗆 No 💮 Foo	d Allergies:   N/A	
Vision Deficits: ☐ Yes ☐ No	Hearing Deficits	: □ Yes □ No	
Can the child follow simple co	mmands: 🗆 Yes 🗆 No		
Recurrent Respiratory Illnesse	s: 🗆 Yes 🗆 No Diagnos	is:	
Previous Swallow Study:   Y	es   No If yes, what ty	pe of study?   MBSS FEES	<u> </u>
Date:	Results:		
Current Diet and Feeding S	_		
□ NPO □ GT/NG Depen	•	• • •	
		Nectar ☐ Honey ☐ N ☐ Breast ☐ Sippy Cup ☐	
		ashed solids $\square$ Soft & bite	
• '' '		$\square$ Some assistance $\square$ Depen	-
Behaviors:   Picky Eating	$\square$ Reflux; Vomiting $\square$ D	ifficulty transitioning to solids	☐ Aversion
Coughing/Choking on: □Liq	uids from a	□Puree □So	lids   Secretions
<b>Current Therapy</b>			
	Therapist 8	Company Name	Therapist Contact Info
Physical   N/A			
Occupational   N/A			

 $\square$  N/A

Speech/Feeding

	,	the referring, please fill out the following:	
Name of provider	Phone number	Fax number	
		•	
Anything you may want us to know	prior to the appointment (feeding	s behaviors, likes/dislikes, etc):	
Please call with any questions prior	to the appointment.		
Please call with any questions prior	to the appointment.		
Please call with any questions prior Name of Person Completing Form:		Date:	