Chan Soon-Shiong
Medical Center
at Windber

**Speech Therapy**
**Pediatric Intake Form**

Child's Name _____ Date of Birth ____/__/_____

Allergies: _____ Fall Risk ☐ yes ☐ No

Medications ☐ Yes ☐ No

*****If Yes Please list all prescription & over the counter medications, also any vitamins and/or herbal supplements*****

| **Medication** | **Dose** | **Route** | **Frequency** |
|---|---|---|---|
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Medical Diagnosis_____
Reason for Referral_____

**Pregnancy History**
Birth Weight ____lbs___oz Gestation: _____
Date of last Physical Exam _____ Results:_____
☐ Natural Child ☐ Adopted Child ☐ Other
How many pregnancies _____ Number of Live Births_____ Miscarriages_____
Single Birth ☐ Yes ☐ No Length of Labor_____ Type of Delivery_____
Babies Condition at Birth_____ Length of Hospital Stay _____

Describe any complications experienced during pregnancy or Labor & Delivery
_____
_____

Please list any exposure to Infection, Toxic Substances, or accidents that occurred during pregnancy
_____
_____

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