DT22504-01

CRANIOFACIAL CLINIC - PATIENT INTAKE FORM
Children's Healthcare of Atlanta - Scottish Rite
Pediatric Dentistry
Speech Pathology Laboratory
Center for Craniofacial Disorders

Patient's Name LAST FIRST MIDDLE PREFERRED

Date of Exam: _____

Medical Record #:

Date of Birth: Age: Yrs. Months Days

Gender: People accompanying patient:

Individual Completing This Form: _____

☐ Intake Forms Given to Parent to update

Primary language in the home is

☐ Intake Forms received from Parent

Interpreter? Name of Interpreter

Who Can We Thank For This Referral?

Primary REFERRAL First Name Middle Last Name Title

Address and Phone Number

Secondary REFERRAL

Parent Concerns

DO NOT Write in gray boxes

Pain Assessment: **Pain?** ☐ NO ☐ YES **Pain Scale** **Pain Level** **Pain Location** **Pain Disposition**

Developmental History Please List Age at Which your child:

Birth Weight was:
Early Development was:
Gestation:
Sat Alone:
Walked Alone:
Toilet Trained:
Used First Words:
Combined Words:
Used Sentences at:

Medical History

Premedicate?: Immunizations are: ☐ Up To Date ☐ Not Current ☐ Other...

Please Check any Conditions that Your Child has Now or had in the Past

☐ Good Health	☐ Fainting	☐ Kidney Disease	☐ Second Hand Smoke
☐ Anemia	☐ Frequent Colds	☐ Liver Disease	☐ Seizures
☐ Asthma	☐ Gastroesophageal Reflux	☐ Lung Disease	☐ Shunt
☐ Bleeding Disorder	☐ Head Injury	☐ Mental Retardation	☐ Skin Disease
☐ Bone Disorder	☐ Heart Murmur	☐ Mouth Breather	☐ Sleeps Poorly
☐ Cancer	☐ Heart Problems	☐ Muscle Disorder	☐ Snores
☐ Cerebral Palsy	☐ High Blood Pressure	☐ Nose/Throat Disorder	☐ Sore Throats Sinus Infections
☐ Diabetes	☐ Hormone Disorder	☐ Other Medical Condition.	☐ Speech Problem
☐ Ear/Hearing Disorder	☐ Hyperactive (ADD-ADHD)	☐ Premature Birth	☐ Stomach Disorder
☐ Eye/Vision Disorder	☐ Hyperactivity	☐ Rheumatic Fever	☐ Other...

CURRENT MEDICATIONS

ALLERGIES

Medical History

LIST PREVIOUS SURGERY(ies)
For Example:
Adenoids?
Ear Tubes?
Cleft Palate?
Dental?

Date	Age	Surgeon	Surgery

FEEDING HISTORY

Early Feeding Difficulties? ☐ Normal Limits ☐ Nasal Regurgitation ☐ Failure to Thrive ☐ No Information in Chart ☐ Other...

Nasal Regurgitation?
☐ Nasal regurgitation was absent.
☐ Nasal regurgitation is present for all/most meals.
☐ Nasal regurgitation is present for less than 50% of meals.
☐ Nasal regurgitation is present only infrequently.
☐ Other...

EDUCATIONAL and SPEECH THERAPY HISTORY

◯ is not in school (home with parent).
◯ is home-schooled.
◯ is in daycare.
◯ is in Early Intervention.
◯ is in Preschool.
◯ is in Elementary School.
◯ is in Middle School.
◯ is in High School.
◯ is in College.
◯ has graduated High School.
◯ has completed a GED.
◯ has graduated College.
◯ Other...

Grade

Years in Speech Therapy

Name of school:

Speech Therapy
☐ is not in speech therapy.
☐ is in speech therapy through the schools.
☐ is in speech therapy privately.
☐ is in speech therapy through the schools and privately.
☐ Other...

Speech Therapist's Name

HEARING HISTORY

☐ Recent testing revealed NORMAL HEARING.
☐ Hearing has not been tested recently but there are NO CONCERNS expressed.

☐ Recent testing revealed hearing/middle deficits and there is ACTIVE MANAGEMENT underway.
☐ Response to sound was not appropriate and a HEARING ASSESSMENT IS RECOMMENDED.
☐ History of CONDUCTIVE LOSS.
☐ History of SENSORI NEURAL LOSS.
☐ Other...

VISION HISTORY

☐ Recent testing revealed NORMAL vision.
☐ Vision has not been tested recently but there are NO CONCERNS expressed.

☐ Recent testing revealed visual deficits and CORRECTIVE LENSES are in use.
☐ Response to visual images was not appropriate and a VISUAL ASSESSMENT is recommended.
☐ Vision has not/can not be tested.
☐ Other...

ADDITIONAL DENTAL VISIT INFORMATION

Dental Provider

Is This Your Child's First Visit to Dentist? ☐ Yes ☐ No

Does your child have a Latex Allergy? ☐ YES ☐ NO ☐ Other...

Has Your Child Experienced Swelling or Itching with

☐ None Reported ☐ Surgery
☐ Latex ☐ Medical Test
☐ Balloons ☐ Non-Citrus Fruits
☐ Dental Visits ☐ Other...

Dental Visits Dates and Service

Source of Drinking Water? ☐ City/County System ☐ Well Water ☐ Bottled Water ☐ Other...

Fluoride Tablets Drops Rinses? ☐ Yes ☐ No ☐ Other...

Injuries to Mouth Face? ☐ Yes ☐ No ☐ Other...

Habits Finger Thumb Sucking or Pacifier Use? ☐ Yes ☐ No ☐ Other...

How Often are Teeth Brushed?

Who Brushes Teeth?