Pediatric and Adult Speech / Swallowing and Feeding Disorders & Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452
tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

FEEDING EVALUATION

Identifying Information

Intake Date: _____
Patient Name: _____ Date of Birth: _____ Age: _____
Parent/Guardians Names: _____
Primary Diagnosis: _____
Pediatrician: _____
Referring Physician: _____
Reason for Referral:
_____
_____
_____

Would you like GSST to share the results of the evaluation with your primary care provider/referring physician: YES NO

Contact Information

Address: _____

City: _____ State: _____ Zip: _____
Home Phone: _____ Main Phone: _____
Email Parent: _____ Email Parent: _____

Social History

With whom does the child live (list all): _____
Siblings:(ages) _____
Primary Language Spoken at Home: _____
School/Daycare: _____
Grade: _____ List any Academic Difficulties_____

Pertinent Past and Current Medical Information

Prenatal/Birth History
Length of pregnancy (Weeks:)_____

Were there any complications during pregnancy or delivery? yes / no
If yes, please explain:

_____
_____
_____

Birth weight _____ Apgar Scores _____
Twin: yes / no If yes: ____ identical ____ fraternal
multiple: yes / no If yes: please indicate number _____

Hospitalization/surgical history
Date(s): _____
Facility: _____
Reason (s) for hospitalization:

_____
_____
_____

Known Precautions/Allergies
Medical allergies: ____ Latex _____ Other: _____
Food allergies: _____ Dairy _____ Gluten _____ Nuts _____ Soy _____
Other: _____
Does your child require an EpiPen for any allergies? ____ Yes _____ No
Food Intolerances: _____ Dairy _____ Gluten _____ Nuts _____ Soy _____
Comments: _____

Current Medications _____ Not Applicable
Medications (include length of use/reason):

_____
_____
_____

Medical History:
Neurologic History/Current Concerns: _____ Not Applicable
HISTORY of neurologic deficits? _____ Yes _____ No
If yes, please describe (e.g., abnormal muscle tone, ataxia, seizures, hyrocephalus):

_____
_____
_____

Has your child ever had any brain imaging studies done? _____ Yes _____ No

CURRENT neurologic status: _____ no concerns _____ concerns _____ regular follow up with neurologist (physician name): _____
If current concerns, please describe:

_____
_____
_____

Has any medical professional ever given your child a specific diagnosis? (mark all that apply)

_____ Developmental Delay/Disorder
_____ Intellectual Disability
_____ Psychiatric Disorder
_____Genetic Disorder: _____
_____Sleep Disorder
_____ Tic Disorder
_____ Metabolic Disorder
_____ Autism
_____ Failure to Thrive
_____ Alcohol Related Disability
_____ Enuresis/Encopresis
_____ Autoimmune Disorder:_____
_____ Other (specify below):

_____ Asthma
_____ Visual Impairment
_____ Hearing Impairment
_____ Ear Infections
_____ Ear Tubes
_____ Speech-Language Delay
_____ Cardiac History: _____
_____ Seizure Disorder
_____ Head Injury
_____ GI History: _____
_____ Acid Reflux: (if yes, age of onset):
_____

_____
_____

Did your child experience ANY illnesses or diseases: If yes, what diseases/illnesses? (please list)

_____
_____

Has your child ever had a hearing evaluation? ___ Yes ____ No
If yes, please explain results: _____
Do you have any concerns with your child's hearing? ____ Yes ____ No
If yes, please explain: _____

Known family history of speech or language problems, special education placements, or learning disability?
Please explain: _____

Related Services:

Has your child ever been previously seen by a

_____ Speech-Language Pathologist
_____ Occupational Therapist
_____ Psychologist
_____Neurologist
_____ Audiologist
_____ Educational Tutor.

_____ Geneticist
_____ Psychiatrist
_____ Physical Therapist
_____ ENT
_____ Developmental Specialist (EI)
_____ Neurodevelopmental Pediatrician

If yes, please specify (dates, diagnoses, type of services provided such as evaluation, therapy, etc):

_____
_____
_____

<u>Developmental History</u>

Current Speech/Communication Skills

Current main mode(s) of communication (select all that apply): _____ Gestures _____ Vocalizations
_____ Speech _____ AAC _____ Other: _____
If using speech, please rate speech skills: _____ Within age appropriate limits _____ Delayed

_____ Impaired
At what age did your child perform the following speech tasks:
_____ Coo _____ Babble (reduplicated) _____ Babble (Variegated) _____ Jargon (Adult like intonation)
_____ First words _____ 2 Word combinations _____ 3+ Word combinations _____ Full sentences
_____ Not Applicable
Is your child regularly being followed by a speech-language pathologist? _____ Yes _____ No
If yes, please provide the name of the SLP therapist/location: _____

Cognition
Has your child ever been tested for an inability to sit still, pay attention, remember things, or learn like other children his/her age? _____ Yes _____ No
If yes, has a formal diagnosis been given? _____ ADD _____ ADHD _____ ASD _____
Other: _____
If no, do you have any concerns in any of these areas? _____ Yes _____ No
if yes, please explain: _____
(If school age) Learning disabilities: _____ Yes _____ No
If yes, please explain: _____
Is your child regularly being followed by an educational specialist? _____ Yes _____ No
If yes, please provide the name of the specialist/school: _____

Current Gross Motor Skills
_____ WFL _____ Delayed _____ Impaired
If delayed or impaired, please check all that apply:
_____ Head Control _____ Trunk Control _____ Tone _____ Mobility _____ Other: _____
Please explain: _____
Is your child regularly being followed by a physical therapist? _____ Yes _____ No
If yes, please provide the name of the therapist: _____

Current Fine Motor Skills
_____ WFL _____ Delayed _____ Impaired
If delayed or impaired, please explain:
_____
Current Sensory Skills
_____ WFL _____ Impaired
If impaired: _____ Hypersensitive _____ Hyposensitive _____ Other: _____
Is your child regularly being followed by an occupational therapist? _____ Yes _____ No
If yes, please provide the name of the therapist: _____

Please share any other concerns you may have regarding your child's development:
_____
_____
_____

Feeding History
Current Oral Feeds Volume: ____ Exclusive (all nutrition received by mouth)
_____ Partial supplementation with tube _____ "Tastes" (for pleasure/stimulation/exposure) _____ N/A

For LIQUIDS, please answer the following questions:
Does your child require liquids to be thickened? _____ Yes _____ No
If yes, please indicate degree liquids are thickened and recipe used: _____

First Took/Used	Current Use/Age Stopped	Comments
Breast ____ N/A Age: _____	Yes / No	
Bottle ____ N/A Age: _____	Yes / No	
No-Spill Cup ____ N/A Age: ____	Yes / No	
Straw _____ N/A Age: _____	Yes / No	
Open Cup _____N/A Age: _____	Yes / No	
Other _____N/A Age: _____	Yes / No	

How many ounces of fluid does your child consume daily? _____
Does your child ever cough or choke with liquids? _____ Yes _____ No
Does your child ever sound gurgly when drinking or immediately after? _____Yes _____No
If yes, please comment:
_____
_____

Please select the types of liquid that is regularly consumed:
_____ Water _____ Breastmilk _____ Formula _____ Milk (specify): _____ _____ Juice _____ Soda
_____ Yogurt drinks
_____ Other: _____
Comment on any preferences of a specific brand of nipple or cup:
_____
Comment on any position:
_____

For **FOODS**, please answer the following questions:
Does your child CURRENTLY take any foods orally? ____ Yes _____ No
If no, please skip this section.

First Took/Used	Current Use/Age Stopped	Comments
Spoon (caregiver) ____ N/A Age: _____	Yes / No	

Fingers (caregiver) ____ N/A Age: _____	Yes / No	
Utensils (Self) ____ N/A Age: _____	Yes / No	
Fingers (Self) ____ N/A Age: _____	Yes / No	
Other _____N/A Age: _____	Yes / No	

Does your child ever cough or choke with foods? _____ Yes _____ No
Does your child ever sound gurgly when eating or immediately after? _____Yes _____No
If yes, please comment:

_____

_____

Please select the types of food consistency (select all that apply) that is regularly consumed:
_____ Thin puree (e.g., baby food) _____ Puree (e.g., pudding) _____ Dissolvable solids (e.g., puffs)
_____ Soft Solids (e.g., cheese, raisins) _____ Hard Solids (e.g., cookies, dry cereal)
_____ Multiple consistencies (e.g., dry cereal with milk)
_____ Difficult to chew foods (e.g., meat, raw vegetables) _____ Other: _____
Does your child require any specialized feeding equipment? if yes, please comment:

_____

Please select the **variety** of foods that your child will eat and provide examples
Fruits: _____ None _____ 1-2 _____ 3-4 _____ More than 5
Comment: _____
Vegetables: _____ None _____ 1-2 _____ 3-4 _____ More than 5
Comment: _____
Grains: _____ None _____ 1-2 _____ 3-4 _____ More than 5
Comment: _____
Dairy: _____ None _____ 1-2 _____ 3-4 _____ More than 5
Comment: _____
Protein: _____ None _____ 1-2 _____ 3-4 _____ More than 5
Comment: _____

Do you or your doctor have any concerns regarding the variety of foods that your child will eat?
_____ Yes _____ No
If yes, please explain: _____

Would you consider your child to be a “picky” eater? _____ Yes _____ No
When did your child’s feeding become a concern? _____
How many different foods does your child eat? _____

Does your child prefer foods that are: _____ Room Temperature _____ Cold _____ Hot _____ N/A

Smell and Taste
Smell: _____ WFL _____ Unknown _____ Heightened _____ Diminished
Taste: _____ WFL _____ Unknown _____ Heightened _____ Diminished
Preference: _____ Sweet _____ Salty _____ Bitter _____ Sour _____ Strong Flavors _____
Other: _____

Would you say that your child gags easily with different foods? _____ Yes _____ No
If yes, please explain: _____
Do you prepare special meals? _____ Yes _____ No
If yes, how many meals per day? _____
Do you feel you have to play games or distract your child to get them to eat? _____ Yes _____ No
If yes, how frequently do you have to use this distraction? _____
Do you feel you have to reward the child to get them to eat? _____ Yes _____ No
If yes, how frequently are rewards used? _____
Do you notice a difference in how much your child eats or how long they stay engaged based on who may be feeding them or different environments? _____ Yes _____ No
If yes, please explain: _____
Are there any other strategies you have tried to support feeding? (e.g, punishment, high calorie supplementation, giving preferred foods, etc.):
_____
_____

Does your child have any of the following symptoms when eating or drinking? (Circle all that apply)

Gagging	Limited volume/not eating enough
Coughing	Difficulty swallowing
Choking	Refuses to swallow/holds food in mouth
Vomiting	Spits food out
Eats a limited variety of food/selective	Trouble chewing
Slow weight gain	Difficulty progressing to table food
Refuses to eat	Other (specify):_____

Mealtime Routines and Introduction of New Foods:
What are the number of planned meals/snacks your child receives daily? _____
Please provide a general mealtime schedule:
_____
_____
_____
How long are mealtimes in general (period of time where your child is engaged in eating?)
_____

Does your child eat at the same time and place as the family? _____ Yes _____ No
Please describe: _____
What type of chair does your child sit in for most meals at home? _____
Does your child stay seated for the mealtime? _____ Yes _____ No
If no, approximately how long will your child sit and eat? _____
How much support is needed during the mealtime to eat/drink? (e.g., feeds independently, caregiver feeds completely): _____

What are your goals for your child's therapy? What do you want your child to achieve by coming to feeding therapy?

_____
_____
_____
_____
_____
_____

Print Name: _____**Signature:** _____ **Date**: _____

garden state SPEECH THERAPY

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Financial Agreement

_____ I hereby give Garden State Speech Therapy, LLC authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.

_____ I authorize the release of any medical or other information necessary to process all claims.

_____ I understand that if payment is not issued by the insurance company within 45 days of the initial filing, I am responsible for following up with my insurance carrier and may be responsible for any payments not paid by my insurance carrier to Garden State Speech Therapy, LLC.

_____ Invoices are due within 15 days of receipt. A 20% late fee will be added to all late bills.

_____ If patient responsibility payment is not received within 30 days, therapy services might be put on hold. All balances more than 30 days old will be charged to the credit card on file.

_____ I understand that if patient responsibility payment is not made within 60 days, my/my child's appointment time will be forfeited until the balance due is paid in full and therapy services might be terminated. I understand that delinquent accounts may be referred to collections, incur interest collection and attorney's fees for which I will be responsible. Garden State Speech Therapy, LLC does not guarantee the same time slot once the payment has been made.

_____ I understand that a valid credit card on file is required for all scheduled appointments.

_____ GSST will re-submit denied insurance claims twice (2 times). All denied claims thereafter will be billed to the client at billed rate. GSST will make every effort to assist with insurance appeals upon request.

_____ All returned checks will incur a $30 service fee.

_____ I understand that it is my responsibility to inform the office of any insurance changes. Any charges incurred after the termination date of insurance policy are my responsibility

_____ All patient responsibility payments are due at the time of service

Date: _____ X_____

Print Name: _____

Parent/Guardian for: _____

garden state SPEECH THERAPY

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Attendance and Cancelation Policy

Consistent attendance of therapy sessions is paramount for progress. We offer consistent scheduling to all clients, with time slots reserved for each client. Our therapists make a commitment to their clients' progress, we ask that our clients make the same commitment by maintaining their attendance. We will make every effort to schedule make ups for all missed sessions. Make up sessions are offered based upon availability of therapists.

_____ We require 24 hour notice for cancellations. All cancelations of office visits **less than 24 hours in advance** and **no-shows** will incur a **$50 charge**. For traveling appointments, the full rate will be charged. **The $50 cancelation fee will be waived if the appointment is rescheduled and attended within 2 weeks. The $50 no-show fee will not be waived and no-show appointments will not be rescheduled**

_____ **Two (2) canceled and not rescheduled sessions in any 10-week period will result in appointment time loss at the discretion of GSST management. Attendance rate of 80% is expected**

_____ **2 consecutive no-shows will result in appointment time loss**

_____ I understand that cancelation and no-show fees cannot be billed to my insurance and are my responsibility.

_____ Sick children will be sent home. We will do our best to reschedule the appointment.

I have read and understood the attendance and cancelation policy. I hereby accept the attendance and cancelation policy in full.

Date: _____ X_____

Print Name: _____

Parent/Guardian for: _____

garden state
SPEECH THERAPY

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Consent and Acknowledgement

Name of client:_____

Consent for care and treatment: As (self/parent/legal guardian), I hereby consent to necessary evaluation, procedures, and/or treatments prescribed by the speech therapist as is necessary in their judgment. I understand that I/my child is under the care of a speech language pathologist. I authorize the release of medical information to Garden State Speech Therapy, LLC for continuity of care.

HIPAA Notice of Privacy Practices: Garden State Speech Therapy, LLC will use and disclose personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law.

_____ _____

Signature Date

_____

Print Name

_____

Relationship to client

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders

www.gardenstatespeech.com / 201-297-9167

All Information Will Remain Confidential

Patient's name_____

Name on card: _____

Billing Address: _____

Credit Card Type: _____Visa _____Mastercard _____Discover

Credit Card Number: _____

Exp. Date:_____ CVV/Security Code:_____

____ I choose to pay my outstanding balance with a credit card. A valid credit card is required to be on file for this option. Please provide the following information.

____ I understand that all balances more than 30 days overdue will be charged to my credit card on file

I hereby authorize Garden State Speech Therapy, LLC to charge the credit card listed above for services rendered. I agree that all sessions booked will be charged at the corresponding rate as stated in the Service Agreement. I agree to keep valid credit card information on file with Garden State Speech Therapy, LLC and to immediately notify Garden State Speech Therapy, LLC if there are any changes to my credit card information. I agree to pay these charges according to my credit card agreement and not to cancel any valid charges, according to this agreement.

_____ _____

Signature Date