ST. FRANCIS DE SALES SCHOOL FOR THE DEAF IN BROOKLYN
GENERAL INTAKE INFORMATION

A. Identifying informationD

Child's name: _____

DOB _____ Age: _____

Primary Diagnosis: _____

Primary caregiver (s) _____

How did you hear about St. Francis?

_____

_____

_____

Child accompanied by: Parent 1 ◯ Parent 2 ◯ Legal guardian ◯ Other: _____

Primary language: English ◯ Spanish ◯ Other: _____

Interpreter needed: Yes ◯ No ◯

How do you communicate with your child at home? Talk ☐ Gesture ☐ ASL ☐ Other

B. EDUCATIONAL HISTORY:

Early Intervention: No Yes. Where & When? _____

Preschool: No Yes. Where & When? _____

Current School Placement (name & location): _____

Describe your child's experience in these schools:

_____

_____

What services does your child receive and how often?

PT _____ OT _____ Speech _____ Vision _____ O&M _____ Counseling _____

Feeding _____ Other: _____

C. Pertinent past and current medical information

C1. Prenatal/birth history

Length of pregnancy (weeks): _____

Delivery: ☐ normal ☐ c-section

Were there any complications during pregnancy or delivery? Yes ◯ No ◯

If Yes, please explain

_____

_____

_____

Birth Weight _____ Apgar Scores _____

as your child been diagnosed with a Syndrome? ☐ CHARGE ☐ Down's ☐ Usher's ☐ Waardenburg's

Other: Name and explain: _____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Twin: ☐ Yes ☐ No If yes: Identical ◯ Fraternal ◯

Multiple: Yes ☐ No ☐ If yes: please indicate number _____

Place of birth (Country, State, City) _____

C2. Hearing history

Did your child have a new born hearing screening? Passed ☐ Needed follow-up ☐

What was the follow-up? Where did the follow up happen and how old was your child?

_____

Age your child was diagnosed with hearing loss? _____

Who diagnosed it and where were they located (hospital)? _____

Does your child use hearing aids ☐ cochlear implants ☐ BAHA ☐ None ☐

At what age did your child begin to wear hearing device/amplification? _____

Does your child wear the device? All day sometimes never

Does your child respond to his/her name when wearing the device? Yes ☐ No ☐

Name of hospital for your child's current hearing services? _____

Name of audiologist: _____

Children with Cochlear Implants:

What age did the child get the implant? _____

Where did the child get the device (name of hospital)? _____

Do any other family members have any type of hearing loss? _____

CURRENT hearing/chronic ear infection status (check) all that apply): No problems ☐

Current issues or Regular follow-up with pediatrician: (physician name, unless previously provided)

_____

Regular follow-up with ENT: (physician name, if not previously provided)

_____

Follow-up with audiologist: (audiologist name, if not previously provided)

_____

If current issues please explain:

_____

C3. Vision History

HISTORY of vision problems? Yes ☐ No ☐

If yes what were the findings? Within Functional Limits ☐ Impaired ☐ Unknown ☐

If impaired, select from the following: Cortical visual impairment ☐ Ptosis ☐ Strabismus ☐

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Other: _____ If box checked, please explain (affected eye (s), Restrictions, etc.)

_____

_____

Current vision status (check all that apply):

No problems ☐ Current issues ☐

Regular follow-up with ophthalmologist: (physician name)

_____

Regular follow-up with pediatrician for visual issues: (physician name, unless previously provided)

Does your child currently use any adaptive vision equipment? Yes ☐ No ☐

If yes, select the type of adaptive equipment: Glasses ☐ Patch ☐ Other

If selected, provide details: _____

If any additional issues, please explain: _____

C4. Hospitalizations/Recent Surgeries

Date (s):

_____ Facility _____

Reason (s) for hospitalization:

_____

_____

Date (s):

_____ Facility _____

Reason (s) for hospitalization:

_____

_____

Additional Hospitalizations:

_____

_____

C5. Known precautions/ Allergies

Medical allergies ☐ Latex ☐ Others: _____

Food allergies ☐ Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other: _____

Does your child require an **EpiPen** for any allergies? Yes ☐ No ☐

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Food intolerances: Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other: _____

Special Diets: Hallal ☐ Kosher ☐ Vegetarian ☐ Ketogenic

Comments: _____

_____

C6. Current Medications Not Applicable ☐

Medication 1: _____ How long been taking? _____

Prescribed for: _____ Prescribed BY: _____

Medication 2: _____ How long been taking? _____

Prescribed for: _____ Prescribed BY: _____

Medication 3: _____ How long been taking? _____

Prescribed for: _____ Prescribed BY: _____

Additional Medications:

_____

C7. Neurology History? Current Concerns Not Applicable ☐

History of neurologic deficits? Yes ☐ No ☐

If yes, please check: abnormal muscular tone (high) ☐ abnormal muscular tone (low) ☐

Anoxia ☐ Ataxia ☐ Brain tumor ☐ Hydrocephalus ☐ Microcephaly ☐ Paralysis ☐ Seizures ☐

Brain Injury ☐ Stroke ☐ TIAs ☐ Tremor ☐ Cerebral Palsy (CP) ☐ Agenesis of the Corpus Collosum Other: ☐

_____

If any checked, please explain: _____

_____

_____

_____

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

If yes, **when** was the testing, **where** was the testing completed, and **what** were the results?

_____

_____

Current neurologic status: No problems ☐ Current issue(s) ☐ Regular follow-up with neurologist (physician's name) _____

Regular follow-up with pediatrician for neurologic issues: (physician name, unless previously provided)

_____

If current issues, please explain: _____

_____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

C8. Cardiac History/ Current concerns Not applicable ☐

HISTORY of heart problems? Yes ☐ No ☐

If, yes please indicate the specific heart problem or suspended problem:

_____

_____

Please check if any of the following **have** occurred: Surgery ☐ Episodes of cyanosis ☐

Altered activity level ☐ Intolerance of specific positions secondary to cardiac condition ☐

Known complications from cardiac condition: CVAs ☐ TIAs ☐ Vocal fold paralysis ☐

Other _____ If any box checked, please explain: _____

_____

Current cardiac status: No problems ☐ Current issue(s) ☐ Regular follow-up with cardiologist (Physician's name)_____

Regular follow-up with pediatrician for cardiac issues: (Physician's name, unless previously provided)

_____

If current issues, please explain _____

C9. Respiratory History/ Current Respiratory Concerns Not applicable ☐

History of respiratory problems: (check all that apply)

Apnea (Obstructive) ☐ Apnea (Central) ☐ Asthma ☐ Bronchitis/bronchiolitis ☐

Bronchopulmonary Dysplasia (BPD) ☐ Malacia (broncho) ☐ Malacia (laryngo) ☐

Malacia (tracheo) ☐ Nasal/Chest Congestion ☐ Pneumonia ☐ Tracheal stenosis ☐

Wheezing ☐ Other: _____

If pneumonia, how many times? ___

Was it ever classified as aspiration pneumonia? Yes ☐ No ☐

If yes, please explain: _____

Approximate number of colds per year (check): Normal ☐ Above Average ☐

Approximate number of upper respiratory infections per year: _____

Tracheostomy tube? Yes ☐ No ☐

If yes, (history of tracheostomy tube), please answer the following: Reason for trach AND

Length of time child had the trach_____

Complications related to the trach (granuloma tissue build-up, etc.): Yes ☐ No ☐

If yes, please explain: _____

_____

Does your child have a **history** of any respiratory support (excluding surgeries)? Check all that apply: Ventilator ☐ BiPap ☐ CPAP ☐ Supplemental oxygen ☐ Other ☐

If yes, please explain: _____

_____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Most recent scope, type of scope (E.g. bronchoscopy; endoscopy), date and results:

_____

_____

_____

CURRENT respiratory status (check all that apply): No problems ☐ Current issues ☐

Regular follow-up with pulmonary: (physician name)

_____

Regular follow-up with respiratory therapist: (therapist name) _____

Regular follow-up with pediatrician: (physician name, unless previously provided

_____

If child has CURRENT issues/needs select from the following: Asthma ☐ CPAP/BiPAP ☐

Congestion (chest) ☐ Congestion (nasal) ☐ Pneumonia ☐ Supplemental O2 ☐

Tracheostomy ☐ Ventilator Use ☐ Wheezing ☐ Other: _____

Please explain: _____

_____

Provide **current respiratory treatment** regarding daily breathing treatments and if child has

Emergency plan in place (i.e. inhalers) ☐ None ☐ Yes, If yes, please explain:

_____

Does your child attend daycare? Yes ☐ No ☐

If child **currently** has a TRACH please answer following questions:

Does your child also require mechanical ventilation? Yes ☐ No ☐

CPAP/BiPAP? Yes ☐ No ☐

If yes, please explain: _____

_____

Supplemental oxygen? ☐ Yes ☐ No If yes, volume/amount _____

Anticipated Length of time child will have trach? _____

Size of tube: _____ Manufacturer: _____

Tolerance of speaking valve/plugging: _____

Frequency of suctioning: Rarely ◯ Occasionally ◯ Sometimes ◯ Frequently ◯ Other ◯

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Viscosity of secretions: Normal ☐ Change in viscosity ☐

If a change in viscosity, please describe?_____

Color of secretions Clear ☐ Not Clear ☐

If not clear, please describe? _____

Does food or liquid come out of the trach? ☐ Yes ☐ No, I yes please describe (i.e. food,

Liquid, both, timing related to oral intake_____

C10. Gastrointestinal History/Current Gastrointestinal (GI) Concerns Not applicable ☐

HISTORY of GI deficits? Yes ☐ No ☐

If yes, check all that apply

Altered peristalsis ☐ Bowel obstruction ☐ Crohn's Disease ☐ Chronic diarrhea ☐

Constipation ☐ Dehydration ☐ Diabetes ☐ esophagitis (Eosinophilic) ☐ Esophagitis (general) ☐

Failure to thrive ☐ GI bleeding ☐ Hypoglycemia ☐ Reflux ☐ Slow gastric emptying ☐

Short bowel syndrome ☐ Vomiting ☐ Other: _____

If yes, please provide additional notes _____

HISTORY of GI surgery: Yes ☐ No ☐

If yes, check all that apply: Colostomy ☐ Fundoplication ☐ Pylorotomy ☐ Short gut ☐

Other: _____

If yes, please explain:_____

_____

_____

Did your child ever receive any alternative feeds? Yes ☐ No ☐

If yes, please select (all that apply): NG-tube ☐ G-tube ☐ J-tube ☐ PEG ☐ PEJ-tube ☐

TPN ☐ Other: _____

Type of feeding received: Bolus ☐ Continuous drip ☐ Combination ☐ Other ☐

Has your child ever had any of the following tests completed?

MBS ☐ FEES study ☐ Upper GI ☐ Barium Swallow ☐ pH probe ☐ Sialogram ☐

Other: _____

If so, please indicate the dates and results of tests. If multiple tests completed only provide the

most recent on the lines below_____

_____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Early oral feeding trials: Chronology of formulas (if child less than 3, please indicate all Formulas trialed/utilized) and any comments on poor tolerance: _____

_____

CURRENT GI status (check all that apply) : No problems ☐ Current issues ☐ Regular ☐ follow-up with gastroenterology (physician name)

_____

Regular follow-up with pediatrician for GI issues: (physician name, unless previously provided) _____

Do you or your doctor have concerns about recent weight gain or weight loss: Yes ☐ No ☐

If yes, please explain _____

Has your child ever had a nutritional consult? Yes ☐ No ☐

If yes, please provide the name of consultant and date last visited with any pertinent comments

_____

Has your child ever had blood tested to determine nutritional deficits? Yes ☐ No ☐

If yes, please provide date of most recent testing and results

_____

If your child currently has reflux, have you ever noted coughing or a "gurgly" voice after the Episode? Yes ☐ No ☐

If your child currently suffers from recurrent vomiting, approximately how many times daily do they vomit? _____

Is your child currently receiving tube feeds? Yes ☐ No ☐

If yes, what Type? NG-tube ☐ PEG-tube ☐ PEJ-tube ☐ G-tube ☐ J-tube ☐

Other: _____

Current rate: _____

Current schedule: _____

Additional current GI issues, please explain: _____

_____

C11. Renal History/Current Renal Concerns Not applicable ☐

HISTORY of renal problems? Yes ☐ No ☐

If yes, check (all that apply) : Acute renal failure ☐ Chronic renal failure ☐ Dialysis ☐

Structural deviations ☐ Related Surgeries ☐ Other: _____

If yes, please explain: _____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

CURRENT renal status (check all that apply): No problems ☐ Current issues ☐ Regular ☐

follow-up with nephrology: (physician name) _____

Regular follow-up with pediatrician: (physician name, unless previously provided)

_____

If current issues, please explain: _____

Does your child **currently** have food/fluid restrictions due to renal problems (i.e. protein, Potassium, sodium, fluid, calcium, and phosphorous intake). Yes ☐ No ☐

If yes, please explain in detail: _____

_____

C12. Craniofacial history/Current Craniofacial Concerns Not applicable ☐

HISTORY: Has your child ever had any known defects of the lip and/or palate? Yes ☐ No ☐

If yes, please explain:

_____

Does your child have a diagnosed syndrome, association, or sequence? Yes ☐ No ☐

If yes, please explain: _____

History of sinus infections? Yes ☐ No ☐

History of resonance pattern deficits? Yes ☐ No ☐

History of surgical repair (s)

If yes, or want to add additional comments, please provide below:

_____

_____

CURRENT craniofacial status (check all that apply): No problems ☐ Current issues ☐

Regular follow-up with plastic surgery (physician name)

_____

Regular follow-up with ENT (physician name)

_____

Regular follow-up with pediatrician: (physician name)

_____

Do you ever notice food or liquid coming out of the nose? Yes ☐ No ☐

If yes, please select:

Frequency? Every meal ◯ Daily ◯ Weekly ◯ Occasionally ◯ Rarely ◯ Other : _____

Type of consistency? Thin liquids ☐ Thick liquids ☐ Puree ☐ Solids ☐

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

With straw use? Yes ☐ No ☐

Position (s) of the child? _____

If additional current problems, please explain:

_____

_____

C13. Dental History/Current Dental Concerns

HISTORY Has your child ever been to the dentist? Yes ☐ No ☐

Most recent dental visit and results:

_____

Has your child ever had dental surgery or any unusual dental findings? Yes ☐ No ☐

If yes, please explain: _____

CURRENT dental status (check all that apply) : No problems ☐ Current issues ☐

Regular follow-up with dentist: (dentist name)

_____

Regular follow-up with orthodontist (orthodontist name)

_____

Does your child have normal dentition (number/placement of the teeth)? ☐ Yes No ☐

If yes to either of the previous questions, please explain:

_____

_____

Are your child's teeth currently brushed daily? Yes No

By whom? Child Parent/caregiver Other : _____

Reaction to tooth brushing: Enjoys Resists Other : _____

If selected "resists" or "other ", please explain:

_____

_____

Additional issues, please explain:

_____

_____

C14. Before leaving medical history are any additional medical specialists involved with child (check all that apply): Dermatology ☐ Psychiatry ☐ Psychology ☐ Other ☐

If yes, please provide physician name (s): _____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

D. Developmental Milestones

D1. 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 ☐

If delayed or impaired please explain:

_____

Is your child regularly being followed by speech-language pathologists? Yes ☐ No ☐

If yes, please provide the name of the SLP therapist/location:

_____

D2. 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 ☐ Autism spectrum ☐

Other: _____

If no, do you have any concerns in any of these areas? 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 specialist/school:_____

D3. Current gross motor skills

Within Functional Limits ◯ Delayed /Impaired ◯ Wheelchair ◯ Stroller ◯ Walker ◯ Braces ◯

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 physical therapist? Yes ◯ No ◯

If yes, please provide the name of the therapist:

_____

D4. Current fine motor skills

Within Functional Limits ◯ Delayed/Impaired ◯ Braces ◯

If delayed or impaired, please explain:_____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Is your child regularly being followed by occupational therapist? Yes ☐ No ☐

If yes, please provide the name of the therapist: _____

D5. Current Sensory Skills

WFL ☐ Impaired ☐

If impaired, please explain: _____

Is your child regularly being treated for these sensory issues Yes ☐ No ☐

If yes, please provide name of therapist (if different from above)

_____

D6. Current Nutritional Status/Feeding History/Responses to Food/Current Skills

a. Current oral feeds volume: Exclusive (all nutrition received by mouth) ☐

Partial supplementation with tube ☐ "Tastes" (for pleasure/stimulation/exposure) ☐ N/A ☐

b. For LIQUIDS, please answer the following questions:

Does your child require the liquids to be thickened? Yes ☐ No ☐

If yes, please indicate degree liquids are thickened and recipe used:

_____

If yes, please indicate the length of time your child has been on thickened liquids:

_____

Does your child CURRENTLY take any liquids orally that do not have to be thickened? Yes ☐

☐ No If no, and never did, please go to section on smell and taste (page 13).

Otherwise please answer the following questions.

How many ounces of food (approximately) does your child orally consume daily? _____

Does your child ever cough or choke with food? 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 apricots) ☐ 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? ☐ Yes ☐ No If yes please

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Comment: _____

_____

_____

Please select the **variety** of foods that your child will eat

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: _____

Meats 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 comment _____

Would you consider your child to be a "picky" eater? Yes ◯ No ◯

Does your child prefer foods that are: Room temperature ☐ Hot ☐ Cold ☐

	First took/used			Current Use			
1.	Breast	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	If no, age stopped: ___
2.	Bottle	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	If no, age stopped: ___
3.	No spill cup	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	If no, age stopped: ___
4.	Straw	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	Comment:_____
5.	Open cup	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	Comment:_____
6.	Other	N/A ☐	Age:_____	Takes/uses now?	Yes ☐	No ☐	Comment:_____

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 while drinking or immediately after? Yes ◯ No ◯

If yes, please comment:

_____

ST. FRANCIS DE SALES SCHOOL FOR THE DEAF
GENERAL INTAKE INFORMATION

Please select the types of liquid that is regularly consumed:

Water ☐ Breastmilk ☐ Formula ☐ Milk ☐ 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, and never did,

Please go to section on smell and taste (page 13) Otherwise please answer the following questions.

First took/used		**Current Use**			
1. Spoon	☐ N/A Age:_____	Now?	Yes	No	Comment: _____
2. Fingers	☐ N/A Age:_____	Now?	Yes	No	Comment:_____
3. Utensils (self)	☐ N/A Age:_____	Now?	Yes	No	Comment:_____
4. Fingers (self)	☐ N/A Age:_____	Now?	Yes	No	Comment:_____
5. Other	☐ N/A Age:_____	Now?	Yes	No	Comment:_____