

Speech-Language-Hearing Case History Form

Identifying and Family Information

Child's Name: _____ Date of Birth: _____ M F
Father's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____

Mother's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____

Doctor's Name: _____ Doctor's Phone: _____

Reason you are seeking help: _____

How did you find out about our services: _____

Child lives with (check one):

- Birth Parents Foster Parents One Parent
 Adoptive Parents Parent & StepParent Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems
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Child's race/ethnic group:

- Caucasian, Non-Hispanic Hispanic African-American
 Native American Asian or Pacific Islander Other _____

Primary language in the home: _____

Primary language spoken by the child: _____

Mother's Place of Employment: _____ Phone: _____

Address: _____

Father's Place of Employment: _____ Phone: _____

Address: _____

Speech Language History

Has he/she ever had a speech evaluation/screening? Yes No

If yes, where and when? _____

What were you told? _____

Has your child ever had speech therapy? Yes No

If yes, where and when? _____

What was he/she working on? _____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc)? Yes No

If yes, please describe. _____

When did you first notice any speech problems? _____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

Does your child appear to have difficulty understanding what you say or following directions? Please explain: _____

Do other people have difficulty understanding your child's speech? Please explain: _____

Does your child rely on gestures to make their needs known? Please explain: _____

Do you think your child's speech has changed in the last six months? Please explain: _____

Has the family made any effort to correct the child's speech problems? Please explain: _____

Your child currently communicates using...

- body language
- sounds (vowels, grunting)
- words (she, doggy, up)
- 2 to 4 word sentences
- sentences longer than 4 words
- other _____

Birth History

Was there anything unusual about the pregnancy or birth? Yes No
If yes, please describe. _____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? Yes No
If yes, please describe. _____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? Yes No
If the child stayed at the hospital, please describe why and how long. _____

Medical History

Has your child had any of the following?

- adenoidectomy
 - allergies
 - breathing difficulties
 - ear tubes
 - ear infections
 - encephalitis
 - high fevers
 - head injury
 - scarlet fever
 - meningitis
 - seizures
 - sinusitis
 - tonsillectomy
 - thumb/finger sucking habit
 - tonsillitis
 - vision problems
- How often? _____

Please describe any illnesses or medical problems your child has had:

Has your child ever been hospitalized, had a serious accident, or had an operation:

Please list any medications your child takes regularly: _____

Last ear/hearing exam or treatment: When? _____ Where? _____
Results? _____

Last vision exam or treatment: When? _____ Where? _____
Results? _____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____	sat alone	_____	grasped crayon/pencil
_____	babbled	_____	said first words
_____	toilet trained	_____	spoke in short sentences
_____	walked	_____	put two words together

How do you view your child's development as compared to other children of the same age? _____

School History

If your child is in school, please answer the following:

Name of school and grade in school: _____

Teacher's Name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with any subjects? _____

Is your child receiving help in any subjects? _____

What do you see as your child's most difficult problem in school? _____

**Is there anything that you would like to learn more about
that would help you and your child?**

Additional Comments

Thank you!

Client Information/Guarantee of Payment

Child's Name _____ **Age** _____ **Date of Birth** _____

Parent/Guardian Name(s) _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cellular Phone** _____

Emergency Contacts (if parent/guardian can't be reached)

Name _____ **Phone 1** _____

Relationship _____ **Phone 2** _____

Parent/Guardian Authorization:

I _____, Parent/Guardian of _____, give permission for my child to receive an evaluation and/or therapy services provided by Children's Therapy Place, Inc. In addition, I agree to pay for services provided by Children's Therapy Place, Inc. Payment for services are due at time of visit, unless other arrangements have been made. Receipts will be generated through our billing office, and mailed to clients to submit to their respective insurances.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

INSURANCE INFORMATION AND AUTHORIZATION FOR PAYMENT

Insured's Name _____
Name of Insurance _____
Insurance ID Number _____
Insured's Date of Birth _____
Insured's Policy Group or FECA Number _____
Employer's Name or School Name _____
Insurance Plan Name or Program Name _____

**** Please submit a copy of your insurance card****

Is there another health benefit plan? ____ Yes ____ No

Secondary Plan of Insurance _____
Insured's Name _____
Name of Insurance _____
Insurance ID Number _____
Insured's Date of Birth _____
Insured's Policy Group or FECA Number _____
Employer's Name or School Name _____
Insurance Plan Name or Program Name _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____ Date _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to Children's Therapy Place for therapy services received.

Signed: _____ Date _____

Children's Therapy Place Inc.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, payment or operations.

I, _____, the parent/guardian of _____ understand that as part of my child's services, PTS/CTP originates and maintains paper and/or electronic records describing my child's service history. I understand that this information serves as:

- ❖ A basis for evaluation and therapy treatment,
- ❖ A means of communication among the many health professionals who contribute to my care,
- ❖ A tool for assessing quality and reviewing the competence of therapists.

I am aware that PTS/CTP has a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I may request a copy of the Notice if I so desire. I also understand that I have the following rights and privileges:

- ❖ The right to review of the notice prior to signing this consent,
- ❖ The right to object to the use of my child's information for directory purposes, and
- ❖ The right to request restrictions as to how my child's information may be used or disclosed to carry out treatment, payment, or therapy operations.

I understand that PTS/CTP is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PTS/CTP reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may request a revised Notice of Privacy Practices at any time by calling the office and requesting a copy or by asking for a copy at my next visit.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Parent/Guardian's Signature

Date