New Client Background Information and Consent

PATIENT INFORMATION

Child's Name ____

Date of Birth____________________ Age ________ Grade ___________ School _________________________

Parents/Guardians ____

Address ____

City, State, Zip ____

Home Phone _______________________________ Cell Mom ____

Cell Dad _________ ________ Work Mom __________________ Work Dad ______________________________

Email 1 _____________________________________ Email 2 ____

Physician's Name _______________________________ Name of Practice _______________________________

Address _______________________________________ Phone Number _________________________________

List all family members with whom your child lives ____

____

Is there more than one language spoken in the home? Yes No

If yes, what is the primary language? ____________________ Other languages ___________________________

How did you find out about PipSqueak Speech Therapy? ____

Please explain why you are requesting an evaluation and/or therapy?

____

Has your child ever received a speech language evaluation or therapy? Yes No

If so, when and where? ____

Is there a history of speech, language, or learning delays in your family? If so, what is the relationship to your child? ____

BIRTH HISTORY

Was your child born full term? ____

Did you experience any complications with your pregnancy? ____

Were there any complications at birth? ____

MEDICAL HISTORY

Has your child experienced any serious illnesses, injuries, or surgeries since birth?________________________

____

Does your child have any medical diagnoses? ____

Does your child have a history of ear infections? _______ How often? __________

How were they treated? ________________________ Has your child had PE Tubes placed? __________

Has your child had his/her tonsils or adenoids removed? ____

Has your child had a hearing assessment? ____

When? ____________ Where? _________________ What were the results?____________________

DEVELOPMENTAL HISTORY

At what age did your child:

Crawl? __________ Walk? _________ Speak first word? _______ Example___________________

Combine 2 Words? _________ Example _____________ Use Sentences?______________________

Do you feel that your child is delayed in other areas (social, feeding, motor, learning etc.)? YES NO
____
Did your child vocalize normally as an infant (cry, coo, babble)? YES NO
Estimate how many words your child currently says spontaneously ____________________________________
Is word order used correctly in sentences? YES NO
How well does your child understand what is being said to him/her? ____________________________________
How does your child interact with other children? ____
How much of your child's speech is easily understood by you (parents)? _____________%
How much of your child's speech is easily understood by others? ___________________%

EDUCATION

Is your child currently in enrolled in school? YES NO
Name of School _______________________________________ Grade Level _______________________
Date enrolled _________________________________ Hours per week of attendance ________________
Performance level:
______ Average ______ Below Average ______ Above Average
Describe any special assistance or help provided in the school setting. _____________________________
____

BEHAVIOR

Does your child display any behaviors that concern you? YES NO
If yes, please describe. ____

MAIN CONCERNS:

Please check all that apply.

_____ Vocabulary size
_____ Lack of interactions
_____ Understanding language
_____ Talking through the nose
______ Academic challenges
_____ Word order
_____ Responding to questions
_____ Following directions
_____ Speech sound errors
_____ Poor reader
_____ Talks quickly
_____ Lack of speech
_____ Stuttering
_____ Feeding
_____ Other

ADDITIONAL INFORMATION:

Please list any other information that would like the speech language pathologist to know or that you feel is important. ____
____

If you would like for PipSqueak Speech Therapy to provide you with documentation so you can file for reimbursement from your insurance company please complete this portion:
Insurance Company: ___________________________ Policy ID # __________________________________
Name of Insured: _______________________________ Group # ____________________________________
Insurance Phone # ______________________________

I give permission for a speech-language pathologist from PipSqueak Speech Therapy to complete a speech & language evaluation and/or therapy with my child. I agree to pay the amount due in full at the time the service is rendered. I understand that although my insurance company provides authorization or states that speech services are covered, that is not a guarantee of reimbursement.

_______________________________________ ___________________________
Parent/Guardian Signature Date