A Speech Connection Clinic

Preferred Days: _____
Preferred Times: _____

Identifying and Family Information:

Patient Name: _____ DOB: _____ Sex:

Address: _____ City: _____ State: ____

Zip Code: _____ Best Contact Phone Number: _____

Mother's Name:_____ DOB: _____ Phone:_____

Email: _____

Father's Name: _____ DOB: _____ Phone: _____

Email: _____

Insurance:

What is your primary Medical Insurance? _____

ID#: _____ Group#_____

Who carries the policy? Name:_____ DOB: _____

Do you have secondary insurance?

If yes, what insurance? _____ ID#_____

Group#_____

Primary Care Physician:

Primary Physician's Name: _____ Phone: _____

Physician's Address _____ Fax: _____

When was last Well Check-up/doctor visit? _____

Emergency Contact:

Name:_____ Phone: _____

Relationship: _____
Other members in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

What is your dominant language? _____

Is there a language other than English spoken in the home?

If yes, which one? _____

SPEECH-LANGUAGE-HEARING

Please explain your concerns for patient's speech:_____
_____

Do you feel patient has a hearing problem?

If yes, please describe. _____
_____

Has patient ever had a hearing evaluation/screening?

Has patient ever had a vision screening? Wears Glasses?

If yes, where and when? _____

What were results? _____
_____

Has patient ever had speech therapy?

If yes, where and when? _____

What was he/she working on? _____

Have you received any other evaluation or therapy (physical therapy, counseling, occupational Therapy, vision, etc.)?

If yes, please describe. _____
_____
_____

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

MEDICAL HISTORY

Has patient had any of the following?

__ Adenoidectomy __ Encephalitis __ Seizures __ Flu __ Sinusitis

__ Breathing Difficulties __ Head Injury __ Sleeping Difficulties __ Chicken Pox

__ High Fevers __ Thumb/Finger Sucking Habit __ Colds __ Measles

__ Tonsillectomy __ Ear Infections __ Meningitis __ Tonsillitis __ Scarlet Fever

__ Mumps __ Vision problems __ Ear Tubes ___ Stroke

Other serious injury/surgery: _____

Hospitalizations? If Yes why and how long? _____

Is patient currently (or recently) under a physician's care?

If yes, why? _____

_____

Please list any medications patient takes regularly: _____
_____

_____

Allergies? _____

(If you are not a minor, please sign and date last page)

Answer remaining sections for patients under 21 years old

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth?

If yes, please describe. _____

_____

_____

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

Was the mother sick during the pregnancy?

If yes, please describe. _____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital?

If child stayed at the hospital, please describe why and how long. _____

_____

_____

Any family history for Speech/Hearing or Medical Diagnosis?

If yes, please explain. _____

DEVELOPMENTAL HISTORY

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

_____ sat alone

_____ babbled

_____ grasped crayon/pencil

_____ said first words

_____ put two words together _____spoke in short sentences

_____ walked _____ toilet trained

Does your child:

- Repeat sounds, words or phrases over and over?
- Understand what you are saying?
- Retrieve/point to common objects upon request (ball, cup, shoe)?
- Follow simple directions ("shut the door" or "get your shoes")?
- Respond correctly to yes/no questions?
- Respond correctly to who/what/where/when/why questions?

Is your child currently communicating using:

- Body language?
- Sounds? (vowels, grunting)
- Word? (shoe, doggy, up)
- 2 to 4 word sentences?
- Sentences longer than four words?
- Other _____

Behavioral Characteristics:

___ cooperative ___ restless ___ attentive

___ poor eye contact ___ willing to try new activities ___ easily distracted/short attention

___ plays alone for reasonable length of time ___ destructive/aggressive

___ separation difficulty ___ withdrawn ___ easily frustrated/impulsive

___ inappropriate behavior ___ stubborn ___ self-abusive behavior

SCHOOL HISTORY

If patient is in school, please answer the following:

Name of school/Daycare and grade in school:_____

_____

Teacher's name:_____

What do you see as the patient's most difficult problem in school? _____

_____

Has your child repeated a grade?

If yes, what grade?_____

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

Is your child having difficulty with any subjects?

If yes, please explain._____

Is your child receiving help in any subjects?

If yes, please explain. _____

ADDITIONAL COMMENTS

_____
_____
_____
_____
_____

Notice: We use information provided by you to collect payment for services from your insurance company, or payment method you provide to us for services. If for any reason your insurance does not pay for services, or the payment method you provide is not valid, the guarantor/responsible party will be responsible for payment of services rendered.

_____ _____

Guarantor/Responsible Party Signature Date