THE SPEECH PARADIGM

WHERE SILENCE IS NOT GOLDEN

Welcome and thank you for choosing The Speech Paradigm, to help meet your speech language pathology needs. We realize there are many options from which to choose and we appreciate the opportunity to assist you with this important process.

The attached **new client** packet includes important information about this practice including insurance, financial and privacy policies. Please take time to fill out as much information as possible regarding your child's developmental history as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming, however it is important that your therapist have as much information as possible prior to your first visit so that she may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals, please include copies with your packet.

Completed packets may be emailed or mailed to us. Please contact us with any questions.

We look forward to meeting you and your child.

Sincerely,

Alexandria Marchak-Guthreau

Owner of The Speech Paradigm LLC

Child's Name: _____

Date of Birth: _____

Parent/Guardian Names:

_____

_____

Billing Address: _____

City: _____State: _____Zip:_____

Home Phone:_____

Cell Phone:_____

Child lives with both parents? Yes____ No ____ If no, with whom does the child live?_____

Primary language spoken in home: _____

Secondary language: _____

Pediatrician: _____

Pediatrician Phone: _____

Referring Physician: _____

How did you hear about us? _____

Previous speech therapy evaluations (list):

_____

Other therapies to date (list):

_____

Describe present problem:

_____

_____

_____

_____

_____

_____

Who noted the present problem? _____

When? _____

What is your child's reaction to the problem?

_____

_____

How does the family react to the problem?

_____

_____

Has there been any significant change in the last six months? _____ If so, what?

_____

_____

How well is your child understood? (i.e., what percentage of the time?)

Parents: _____ Younger siblings: _____ Older siblings: _____ Grandparents: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

Describe what it is like to have a conversation with your child:

_____

_____

_____

PRENATAL/BIRTH HISTORY

Full Term: Yes_____ No_____ If no, how many weeks? _____

Birth Hospital: _____ State: _____

Illnesses or accidents during pregnancy:

_____

_____

_____

Use of alcohol, tobacco or medications during pregnancy:

_____

_____

_____

Birth weight: _____ Delivery: Vaginal_____ Cesarean_____ N.I.C.U.- Yes_____No____

Breech (Feet First) _____ Head First_____ Respiratory Issues at birth: _____

Other unusual conditions that may have affected pregnancy or birth?

_____

_____

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

Seizures _____ High fevers_____ Chicken pox_____

Whooping cough/Diphtheria _____ Croup _____ Pneumonia_____

Tonsillitis_____ Meningitis_____ Encephalitis_____ Rheumatic fever_____

Tuberculosis_____ Sinusitis_____ Chronic colds_____ Enlarged glands_____

Thyroid_____ Asthma_____ Heart trouble_____

Explain any checked items here:

_____

_____

Are immunizations current? Yes_____ No_____ Have you traveled outside the U.S. within the past 60 days? _____ If so, where?

_____

_____

CURRENT GENERAL HEALTH

**Has your child had any earaches/ear infections? Yes_____ No_____

Eustachian tubes? _____

If chronic, please explain frequency here:_____

_____

Allergies? Yes_____ No_____ If Yes,

Describe_____

_____

Any other serious or recurrent illnesses?

_____

_____

Any operations? Yes ____ NO_____ If yes, please

Describe_____

_____

Any accidents/falls involving trauma to the head?

_____

_____

Any medications? If Yes, please list along with dosage and # per day (a preprinted list is also acceptable)

_____

_____

Vision problems? Yes _____ No_____ If Yes, Past_____ Current_____

Please Describe:_____

Hearing difficulties: Yes_____ No_____ Dental problems? Yes_____ No_____

If Yes, please explain

_____

_____

Other Medical History not listed above:

_____

_____

DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed) sat up alone _____crawled _____ walked _____toilet trained _____ dressed independently_____ tied shoes _____

Is the child left or right handed?

_____

Attention span-for self-directed activities: _____ Adult-directed: _____ Bedtime: _____

Does your child sleep well? _____

Does your child respond typically to: Light? _____ Sound? _____

People? _____ Does your child: Play with others? _____

Who? _____

Cry appropriately? _____ Laugh? _____ Smile? _____

Get upset easily? _____

Have difficulty calming? _____ Have difficulty sitting still? _____

Sleeping issues? _____Have eating issues? _____ Have attention issues? _____

Have difficulty transitioning from one activity to another? _____

Perseverate on objects or activities? _____

Have complicated routines for bed, bath, mealtime, etc. _____

Cover his/her ears in response to otherwise typical sounds/noises? _____

Have difficulty with daily living activities (tooth brushing, hair washing, etc.) _____

Dislike having their hands dirty? _____

Make wants/needs known? _____

How?

_____

_____

Does your child exhibit unusual behavior (explain)?

_____

_____

FEEDING HISTORY

Difficulty latching to bottle or breast? _____

If so, please explain:

_____

_____

Fed self independently _____ Weaned from bottle/breast_____

Able to use: open cup_____ spoon _____ straw _____

Any difficulty? _____ If so, explain:

_____

_____

Swallowing: _____Chewing: _____ Drinking: _____ Blowing: _____ Drooling: _____ Orally Defensive: _____

Food Allergies:

_____

_____

Favorite Foods:

_____

_____

Aversive Foods (if any):

_____

_____

LANGUAGE DEVELOPMENT

Age when your child spoke first word: _____combined words: _____

spoke in sentences: _____

What was your child's first word(s)?

_____

_____

First sentence?

_____

_____

_____

Which sounds (if any) are of concern?

_____

_____

How many words can your child say? _____ (List if fewer than fifteen)

_____

_____

How many words are your child's sentences? _____

Does your child have any difficulty understanding you? _____ If yes, please describe:

_____

_____

_____

Does your child have difficulty following directions? _____ Describe

_____

_____

Any speech or hearing problems in the immediate or extended family (explain)?

_____

_____

SOCIAL DEVELOPMENT

Names and ages of siblings:

_____

Other adults living in the home:

_____

Moves prior to age 10: _____Relationship/s with peer:_____

Number of regular playmates: _____ Ages: _____

Genders: _____

Activities shared with parents and siblings:

_____

_____

_____

How does your child handle frustration?:

_____

_____

_____

_____

Conflict?:

_____

_____

Separation?:

_____

_____

Regular responsibilities?:

_____

_____

Favorite places?:

_____

_____

Unfamiliar People?:

_____

_____

How many minutes/hours of television does your child watch per day?_____Electronics?_____

What motivates your child most?

_____

What discipline methods work best?

_____

SCHOOL HISTORY

Child's Current School: _____

Grade: _____

Child's performance educationally:

_____

Receiving special services at school: Yes_____ No_____

If Yes, what services?

_____

_____

Does your child currently have an IFSP or IEP?

_____

How does your child's teacher describe his/her performance?

_____

Has the teacher expressed any concern? Yes_____ No_____ If so, explain:

_____

_____

_____

Family Medical History:

_____

_____

_____

_____

What do you hope to have happen as a result of this evaluation?

_____

_____

Anything else you would like us to know?

_____

_____

CONTACT INFORMATION

At times, we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: ***ONLY Home address, one phone number and one e-mail address are required. Please report primary contact only.***

Mom/Dad/Guardian Home Phone: _____ Ok to leave message: Yes_____ No_____

Mom/Dad/Guardian Cell Phone: _____ Ok to leave message: Yes_____ No_____

Mom/Dad/Guardian Email: _____Ok to Email Messages: Yes____ No_____

Please list anyone else who may be with the client during therapy:

1._____

2._____

3._____

*****Unless authorized in advance by parent/s or legal guardian/s, client information and therapy recap will only be provided to parent/s or legal guardian/s.**

PARTY RESPONSIBLE FOR PAYMENT

Name: _____ DOB: _____

SSN: _____ Phone: _____

Address:_____

Employer Name: _____ Contact Phone:_____

Company Address:

_____

**I have read and understand the payment policy. Signature:

_____

INSURANCE BILLING INFORMATION: _____ Card Provided

Primary Insured**:** _____ DOB: _____

Primary Insurance Carrier: _____

Phone Number: _____

Billing/Claim Address: _____

City: _____ State: _____

ID #: _____

Group #: _____

Secondary Insurance: _____

Policyholder Name: _____

DOB: _____

Phone Number: _____

Billing/Claim Address: _____

City:_____ State:_____

Policy Group or #: _____

Group #: _____

_____NOTE: As a courtesy, we will verify your insurance benefits. However, due to continuous inconsistent information provided by the insurance companies, verification is not a guarantee of payment. Payment is ultimately the responsibility of the patient/guarantor. If your insurance does not pay for services, it is YOUR responsibility.

****Please bring your driver's license and insurance cards to the first appointment.**

_____Assignment of Benefits (insurance patients only):

I_____, authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to The Speech Paradigm of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder: _____

Date:_____

_____RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided a copy of The Speech Paradigm's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of The Speech Paradigm's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. 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 understand that by refusing to sign this consent or revoking this consent, The Speech Paradigm may refuse to treat me. I further understand that The Speech Paradigm reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): _____

Date: _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Patient Signature (if over 18 years or emancipated):_____

Date: _____

For minor's- Legal Guardian Signature: _____

Date: _____

CONSENT TO AUDIO OR VIDEO RECORDING

I consent to allowing this speech therapy session to be recorded via audio or video. I understand the purpose of this recording is to provide assessment points and tools of measurement.

I have been advised it will not be released for use in any public material or presentation.

Patient Signature (if over 18 years or emancipated): _____

Date_____

For minor's- Legal Guardian Signature: _____

Date_____