Identifying and Family Information:

Patient Name: _____ DOB: _____ Sex: M F

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Email: _____

Insurance

What is your primary Medical Insurance? _____

ID#: _____ Group#_____

Who carries the policy? Name: _____ DOB: _____

Do you have secondary insurance? ___ yes ___ No

If yes, what insurance? _____ ID#_____ Group#_____

Primary Physician's Name: _____ Phone: _____

Physician's Address _____ Fax: _____

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

Emergency Contact: Name: _____ Phone: _____

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? __ Yes __ No

If yes, which one? _____

SPEECH-LANGUAGE-HEARING

Please explain your concerns for patient's speech._____

Do you feel patient has a hearing problem? __ Yes __ No

If yes, please describe. _____

Has patient ever had a hearing evaluation/screening? __ Yes __ No

If yes, where and when? _____

What were results? _____

_____

Has patient ever had speech therapy? __ Yes __ No

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.)?
__ Yes __ No

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	
__ Allergies	__ 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: _____

Is patient currently (or recently) under a physician's care? __ Yes __ No

If yes, why? _____

Please list any medications patient takes regularly: _____ *(Please list in additional comments on last page if more room is needed)*

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

Answer remaining sections for patients under 21 years old

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

E-mail: _____

Father's Name: _____DOB:_____ Phone: _____

E-mail: _____

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

_____

_____

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

_____

DEVELOPMENTAL HISTORY

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

_____ sat alone

_____ babbled

_____ put two words together

_____ walked

_____ grasped crayon/pencil

_____ said first words

_____ spoke in short sentences

_____ 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?

Your child currently communicates using:

___ Body language

___ Sounds (vowels, grunting)

___ Words (shoe, doggy, up)

___ 2 to 4 word sentences

___ sentences longer than four words

Behavioral Characteristics:

___ cooperative ___ restless ___ attentive ___ poor eye contact ___ stubborn

___ willing to try new activities ___ easily distracted/short attention ___ withdrawn

___ destructive/aggressive ___ separation difficulty ___ self-abusive behavior

___ plays alone for reasonable length of time ___ easily frustrated/impulsive ___ inappropriate behavior

SCHOOL HISTORY

If patient is in school, please answer the following:

Name of school and grade in school: _____

Teacher's name: _____

Has your child repeated a grade? __ Yes __ No If yes, what grade _____

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

Is your child having difficulty with any subjects? __ Yes __ No

If yes, what subjects? _____

Is your child receiving help in any subjects? __ Yes __ No

ADDITIONAL COMMENTS YOU WOULD LIKE US TO KNOW?

_____

_____

_____

_____

_____

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. Payment is due at time services are rendered.*

Cancellations/No show*: Our internal system sends text and email reminders of your scheduled appointments. Failure to cancel a scheduled appointment within 24 hours of your appointment time, will be charged a $25 fee per visit.*

Notice of consent for treatment*: By signing this form, you are agreeing to give Texas Speech Pathways consent for testing and treatment of your/or your minor child's, speech disorder via speech therapy.*

_____ _____

Guarantor/responsible party signature Date

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