Speech Therapy Services
502 S. Wheat Ave.
Bainbridge, Ga 39819
229-246-4088

Child Case History Form

I. Patient Identifying Information:

Last Name_____ First Name_____ M.I._____

Address: _____ City:_____

State: _____ Zip: _____ Home

Phone:_____

Cell Phone_____ Alternate Phone#: _____

D.O.B. _____ Doctor: _____ S.S.#_____

Insurance: _____ Number: _____

II. Parent/ Guardian Information:

***Please list two contacts**

Last Name _____ First Name _____

D.O.B. _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Other: _____

Last Name: _____ First Name: _____

D.O.B. _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Other: _____

A. Has your child been referred to or is currently being served by Babies Can't Wait?
_____Yes _____No

B. Does he/she have an IEP/IFSP? _____

Names and ages of other children in family:

NAME	**SEX**	**AGE**	**SCHOOL/GRADUATE**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. History of Speech Problem

Describe child's speech problem as it appears to you.

_____

_____

When was the problem first noticed? _____

By Whom? _____ Describe any change in the problem since it began.

_____

_____

Has child ever had any speech or language testing or therapy? _____

Where? _____

Date began_____ Date ended _____

Results_____

_____

Does anyone in the household speak a language other than English? _____

What languages? _____

Please check behaviors that describe your child.

_____Looks happy	_____Appears sad
_____Non-Compliant	_____Exhibits one or more, rocking, hand flapping, twirling
_____Even Tempered	_____Is affectionate
_____Throws/breaks	_____Cries frequently
_____Very Active	_____Calm and Quiet
_____Self-Injurious	_____Has trouble sleeping
_____Friendly/outgoing	_____Very Independent
_____Distractible	_____Seems Unusually fearful
_____Dependent on adults	_____Aggressive to others
_____Tantrums/Screaming	_____Picky Eater
_____Plays well with peers	_____Climbs with no fear
_____Prefers to play alone	_____Doesn't respond normally to pain
_____Jibberish/Jargon speech	_____Walks on tiptoes
_____Poor eye contact	_____Sensitive to noise
_____Sensitive to smell	_____Difficulty transitioning from one activity to another

IV Medical History

A. Birth History

Pregnancy was: Normal_____ Complications_____

Explain complications:_____

_____

_____

Full Term: _____

Premature: _____ Describe: _____

_____

Please list and describe any accidents, operations or hospitalizations your child has had:

_____

_____

_____

a. Developmental Milestones

1. Motor Milestones

At what age did the following occur?

Rolled over alone _____ Sat alone _____

Crawled _____ Stood alone _____

Walked unaided _____ Fed with spoon _____

Toilet trained _____ Dressed/Undressed self _____

2. Speech-Language Milestone

Did child make cooing or babbling sounds during first 6 months? _____

When did your child say first words? _____

What were your child's first words?

_____

At what age did child begin to put 2 or 3 words together? _____

Does child prefer to talk or gesture? _____

Does your child understand what you say to him/her? _____

Will child get common objects when asked? _____

3. Fluency Development (for stuttering only)

Does your child stutter? _____ If so, fill out the Fluency Questionnaire.

4. Voice:

Is there a concern about voice quality? Yes _____ No _____

If so, Does your child exhibit any of the following

_____ hoarseness _____ harshness

_____ too loud _____ too soft

_____ pitch breaks _____ loss of voice

5. Swallowing

Are you concerned about child's ability to chew, swallow foods and/ or liquids?

Yes _____ No _____

If yes, dos child exhibit

_____ coughing strangling _____ Pocketing food in mouth

_____ throat clearing _____ Other (describe) _____

_____ excessive drooling _____

Please check any illnesses your child had/has and include age at which illness occurred

	age		age
( ) adenoidectomy	_____	( ) allergies	_____
( ) convulsions	_____	( ) ear ache	_____
( ) ear infection	_____	( ) pneumonia	_____
( ) tonsillectomy	_____		
( ) Food Allergies	_____Yes	_____No	

Please list Food Allergies_____

_____

V. General Health

a) General Information

How would you rate your child's general health?

Good_____ Fair_____ Poor_____

Is your child presently on any medication? If so, please list all

_____

Any recent changes in medication or new diagnosis?_____

_____

b) Hearing Development

1. Are you concerned about your child's ability to hear?_____
2. Does your child react consistently to sound?_____
3. Is your child overly sensitive to noise?_____
4. Can your child turn to the direction from which a sound is coming? (i.e. turns head toward radio when it's turned on by someone else.)_____
5. Does your child have frequent ear infections?_____
   Please describe any treatment he/she has received for ear infections.

   _____
6. Does your child wear a hearing aid? Yes_____ No_____
7. When was your child fitted for hearing aid_____
8. Has your child's hearing been screened/tested? If so, please list all.

   _____

   _____

Print Name: _____

Parent/Guardian Signature: _____

Date: _____

Speech Therapy Services, P. C.

502 S. Wheat Avenue
Bainbridge, GA 39819
Phone-(229) 246-4088 Fax-(229) 246-0205

***** INFORMATION AND CONSENT*****

CHILD'S LAST NAME_____**FIRST NAME**_____**M.I.**___

ADDRESS:_____**PHONE NUMBER:**_____

CHILD'S BIRTHDAY:_____**CHILD'S DOCTOR:**_____

SOCIAL SECURITY NUMBER:_____

MEDICAID/PEACH STATE NUMBER/WELLCARE NUMBER:_____

PRIMARY INSURANCE NAME:_____**NUMBER:**_____

Individual Education Plan (IEP) and Individualized Family Service Plan (IFSP):

If your child has an IEP/IFSP, we must be provided a copy. **Choose one:**

_____I am attaching my child's IEP from his/her local school agency.

_____My child does not have an IEP.

As part of the child development program at this daycare, speech/language screenings are encouraged on all children. With parental permission this daycare will arrange a speech and language screening for your child by Speech therapy Services, P.C. The screening will be provided by licensed speech therapists and include the following areas: speech, voice, fluency, swallowing, language, and pre-school/language skills. Results will be shared with you and the daycare. If your child meets the requirements for further formal evaluation and you wish for your child to receive speech therapy, a consultation with your child's physician should determine whether he/she will receive medically necessary speech therapy at your child's facility, or if a school system referral is indicated. If it is determined your child requires medically necessary speech therapy we can discuss financial arrangements with you or bill your insurance company.

Notice of Privacy Practices:

Speech Therapy Services, P.C. is required to provide our patients with a privacy notice regarding our legal duties and policies to protect your health privacy. Our practice is dedicated to maintaining the privacy of your individual identifiable health information (IIHI). This notice serves to inform you that Speech Therapy Services, P.C. uses your personal health information primarily for treatment, obtaining payment, and consulting with necessary health and educational members of this facility, including your doctor and his/her staff. You may obtain a complete copy of our office procedures and privacy practices by contacting our office at the above location. If you have any questions or concerns, do not hesitate to call the speech therapy office at 246-4088 or talk to the staff at the daycare.

I have read and understand the process of speech therapy services, including screenings, evaluation, treatments, and privacy policies at Speech Therapy Services, P.C. and my child's daycare. I give permission for Speech Therapy Services P.C. to screen, evaluate, and treat my child as indicated at the daycare. I understand the results of the screening/evaluation will be shared with me and recommendations concerning therapy will be made at that time. I authorize the staff at Speech Therapy services, P.C. to discuss protected health information with the caregivers, physicians and insurance company listed above for this patient. I authorize Speech Therapy Services, P.C. to follow the necessary steps to bill this patient's insurance including the release of information to insurance providers and billing for services provided.

_____

Parents Signature

SPEECH THERAPY SERVICES, P.C.
502 South Wheat Avenue
Bainbridge, GA 39819
(229) 246-4088 • (229) 246-0205 Fax

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

NAME_____ DOB:_____

I HEREBY REQUEST AND AUTHORIZE:
NAME:_____

ADDRESS:_____

_____

RELATIONSHIP:_____

TO OBTAIN FROM OR RELEASE TO:
NAME:_____

ADDRESS:_____

_____

_____

RELATIONSHIP:_____

THE FOLLOWING INFORMATION:_____

_____

FOR THE PURPOSE OF:_____

_____

All Information I Hereby Authorize To Be Obtained From/By This Agency Will Be Held Strictly Confidential And Cannot Be Released Again Without My Written Consent. I Also Authorize The Use Of Clinical Observation And Case Discussion For Professional Purposes.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

_____
RELATIONSHIP TO PATIENT

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

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I HEREBY REQUEST AND AUTHORIZE:
NAME:_____

ADDRESS:_____

_____

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THERAPY ATTENDANCE POLICY AND GUIDELINES

Regular and consistent treatment plays a critical role in your child's progress and ability to achieve goals. In order to help your child achieve their goals and receive high quality therapy services, we have established an attendance policy and guidelines to help ensure that every child receives the time and attention they deserve.

Please initial that you have read each guideline.

_____Please arrive on time for therapy sessions. If you are tardy, your child's therapy session cannot be extended to accommodate your late arrival.

_____If you need to cancel an appointment, please call 24 hours in advance to notify us at (229) 246-4088. We will attempt to re-schedule your appointment whenever possible. If your call is not during our normal business hours, please leave a message on our general voice mail. Speech Therapy Services reserves the right to assess a $45.00 cancellation fee for appointments cancelled with less than 24-hour notice.

_____Clients who miss 3 scheduled appointments without advance notice (no call/no show) and/or frequently missed appointments, will be removed from the regularly recurring treatment schedule, placed on a waiting list, and their physician will be notified.

_____Repeated cancellations or no shows will be reported to your referring physician and may result in discontinuance of therapy.

_____Parents should not leave the premises during their child's appointment.

I have read and understand Speech Therapy Services' Attendance Policy and Guidelines and agree to comply.

_____

Child's Name

_____ _____

Parents/Guardian Signature **Date**