ACCESS
SPEECH THERAPY

Child Case History Form

Date: _____

FAMILY AND MEDICAL HISTORY FORM

The information you provide will help our staff determine the care you need and the tests administered during your child's evaluation. A child's individual background, cultural experience, and family support are important factors in determining a treatment plan for your child.

General Information:

Child's Name:_____(circle one) Male/Female Date of Birth: _____
Parent/Caregiver Names:_____
Home Address:_____City:_____State:__ Zip: _____
Home Phone:_____Business Phone:_____Cell:_____
Best # to call: (please circle one) Home / Business / Cell Email address: _____
Native Language(s) spoken in the home:_____Primary language of child: _____
Emergency contact name and phone number: _____
Who referred you to Sensational Kids? _____
Who is your child's Pediatrician or Family Doctor?_____
Address:_____Phone:_____Fax: _____
Is your child in school? Yes or No If yes, where?_____
What grade?_____Is child in any special classes or have special needs? _____
Does your child have an IEP? Yes or No If yes, we need a current copy returned with this form

Reason for visit:

Briefly state the reason your child needs an evaluation (include reasons for each evaluation if seeking more than one service)

_____
_____

When were the problems first identified?_____By whom? _____
Is your child aware of the problem? If so, how does the child feel? _____
How does your child usually communicate (ex. gestures, single words, short phrases, sentences)?
_____

Family Information:

Father's Name: _____Date of birth:_____
Occupation:_____Highest Educational Level: _____
Relationship to child: (please circle): Biological Adoptive Step Foster Other

Mother's Name:_____Date of birth: _____
Occupation:_____Highest Educational Level: _____
Relationship to child: (please circle): Biological Adoptive Step Foster Other

Please list siblings and/or anyone else that lives in the home:

Name	Age	Relationship to the child
1		
2		
3		
4		
5		

Does child have caregiver outside of the home?_____
If yes, when is child with this caregiver? _____

Is there anything about your religious beliefs we should know that may impact therapy or activities chosen for therapy? (ex. holiday worksheets, etc.)

_____

Is your child on a specific or special diet? (ex. gluten, casein, food coloring, sugar, etc.) _____

_____

What are your child's favorite activities, things to eat, and/or cartoons, which can be used as motivators during therapy? (ex. Pokémon, Thomas the Train, Dora, goldfish, pretzels, Skittles)

_____

_____

What activities does your child participate in regularly? (ex. soccer, church, gymnastics)

_____

Child / Family Concerns and Goals:

Please describe what you want your child to achieve with the help of therapy. (What would you like your child to do that he/she can't do now?)

1. _____ 3. _____
2. _____ 4. _____

Medical History:

Were there any complications during pregnancy or delivery of your child? _____
If yes, please describe:_____
Gestational age at time of delivery (or # of weeks early or late): _____
What type of delivery (please circle one)? Vaginal Cesarean Section = elective or emergency
Birth Weight: _____ Length:_____
Was your child in the NICU? _____ If yes, how long? _____

Please make sure to include an explanation for any questions answered "yes."

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Frequent Colds/Respiratory Illness			
2	Frequent Strep throat/sore throat			
3	Frequent Ear Infections (tubes placed?)			
4	Birth defect/genetic disorder			

Please make sure to include an explanation for any questions answered "yes."				
ITEM	**DESCRIPTION**	**YES**	**NO**	**EXPLANATION**
5	Allergies or asthma			
6	Heart condition			
7	Visual disorder/vision problems			
8	Neurological disorder			
9	Seizures or convulsions			
10	Hearing Loss/Ear disorder			
11	Head injuries or concussions			
12	Any major childhood illness (pox, croup, measles, mumps, meningitis etc.)			
13	Hospitalization/surgery			

Has your child had any difficulties with feeding (ex. sucking, swallowing, drooling, chewing, reflux, choking)?
Yes___No___If yes, describe:_____

List current medications your child is taking, if any (please include any over the counter medications or medications given as needed): _____
_____

***Please note: If medications change at any time before evaluation or services begin, please provide written documentation to include in your child's records.**

Is your child ALLERGIC to any foods?
Yes ___No__ If yes, what? _____
Please list reactions to allergy along with severity: _____

Is your child ALLERGIC to any medications?
Yes ___No__ If yes, what? _____
Please list reactions to allergy along with severity: _____

Does your child use any special equipment for daily activities? Yes___No___
(ex. glasses, hearing aide, splints, wheelchair, etc.)
If yes, please list: _____

Developmental History:
Please indicate the age when your child first performed each of the following INDEPENDENTLY. (It is okay to list an approximate age.) Please mark whether you believe your child accomplished the milestone Early, On Time, or Late. If your child has not yet achieved the milestone, write NA in the age column.

MILESTONE	EARLY	ON TIME	LATE	If late, approximately how old was the child?
Said first words / named single objects				
Used simple questions (ex., where's mom?)				
Followed simple 1 step directions				

MILESTONE	EARLY	ON TIME	LATE	If late, approximately how old was the child?
Said 2-3 phrases				
Sat unsupported				
Crawled on hands and knees				
Walked by self				

Please check the tasks your child can do independently at this time:

Drink from: ___Bottle ___Spouted or special cup_____straw ___Regular cup ____blows out candles
Feed Self: ___Finger feeds ___Eats with spoon ___Eats with fork____Cuts with knife

Brush teeth: ___Tolerates parent ___Attempts to brush, but requires assistance ___brushes independently
Undressing: ___Shirt____Pants____Underwear____Socks____Shoes
Dressing: ___Shirt____Pants____Underwear____Socks____Shoes
Shoelaces: ___Ties shoelaces____Fastens Velcro shoes
Buttons: ___Opens large PJ buttons ___Opens small dress shirt buttons
___Fastens small dress shirt buttons____Opens button on top of pants
Zippers: ___Pulls down to open_____Pulls up once pin is placed by adult ___places pin and pulls up

Bladder: ___Trained days ___Trained nights ___Bowel trained

Sleeping: ___Sleeps all night ___Wakes up frequently
___Needs special routine (ex. music, light etc.) If yes, please explain routine:
_____
_____

Has your child had problems with any of the following (beyond expected for child's age)?

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Drooling			
2	Thumb sucking			
3	Temper tantrums/Meltdowns			
4	Head banging			
5	Aggression/destructiveness			
6	Nervous habits (nail biting, etc.)			
7	Under or over reactive to sounds			
8	Under or over reactive to clothing or touch			
9	Under or over reactive to taste			
10	Under or over reactive to smell			
11	Any unusual fears?			
12	Socializing with neighborhood children			
13	Socializing with classmates			
14	Socializing with family			

***If you marked yes to questions 12, 13, or 14 please complete the next section "Social". If not, please continue on to "Family Stressors."**

Social:

Does your child demonstrate difficulty with any of the following social skills?

_____Initiating/responding to greetings/farewells of peers _____Sustaining activities with peers

_____Maintaining the "give and take" of conversations _____Initiating conversations with peers

_____Responding to questions during conversation _____Asking questions during conversation

_____Maintaining eye contact during conversation _____Expressing verbally how she/he is feeling

_____Recognizing facial expressions, non-verbal cues, or "body language" of others

Family Stressors:(please note if any of the following stressful events happened in the last 12 months)

ITEM	DESCRIPTION	YES	No	EXPLANATION
1	Marital separations/divorce			
2	Death in the family			
3	Financial crisis			
4	Job change/difficulties			
5	School problems			
6	Legal problems			
7	Medical problems			
8	Household move			
9	Extended separation from parents			
10	Other stressful event			

Speech and Language:

Which of the following do you think your child understands?

_____His/Her own name _____Family names _____Names of objects

_____Names of body parts _____Simple directions _____Complex directions

_____Conversational speech

What methods does your child use for letting you know what he/she wants?

_____Looking at objects _____Pointing at objects _____Gestures

_____Crying _____Vocalizing/grunting _____Physical manipulation

_____Single words _____2-3 word combinations _____Sentences

Which of the following best describes your child's speech?

_____Easy to understand _____Difficult for parents to understand

_____Difficult for others to understand _____Almost never understood by others

_____Different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

_____Is easily frustrated when not understood

_____Does not seem aware of speech/communication problem

_____Has been teased about his/her speech

_____Tries to say sounds or words more clearly when asked

Does your child have difficulty producing certain sounds? Yes or No If so, which sounds? _____

Does your child stutter when attempting to say a word? Yes or No

Do you have concerns about your child's voice? (too soft, too loud, etc.) Yes or No
What is the parent's reaction to child's speech? _____
_____
_____
When was the speech difficulty first noticed? _____
By whom? _____
Describe your child's current communication status (ex. nonverbal/verbal, sign language, gestures, PECS, etc.)
_____

Has your child been evaluated or received therapy this calendar year, here or at any another facility? Yes/No

*If yes, and it has been in the last six months for the same therapy you are interested in receiving at our facility, please speak with the front office regarding transferring the evaluation.

If yes, please list below:

Previous evaluations/services:	*Who*	*Where*	*When*
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Psychologist			
Other			

Focus and outcomes of above therapies: _____
_____

Billing Information for Out-of-Network Insurance Carriers:

If we are out-of-network with your insurance company, full payment of service is due the day of service. We will submit a claim on your behalf as a courtesy. Depending on your insurance plan, out-of-network benefits may be payable after your deductible is met. Some carriers will reimburse you directly, while others will reimburse the clinic. If the clinic is reimbursed the amount will be credited to your account and future payments for services will be adjusted accordingly. Written reports will be provided upon request of insurance company as needed.

Primary Insurance Information:

Insurance Co. Name:	_____	Phone#	_____
Group #	_____	ID #	_____
Name of Sponsor:	_____	Employer's Name:	_____
Sponsor SSN#	_____	Sponsor DOB:	_____

Secondary Insurance Information:

Insurance Co. Name:	_____	Phone#	_____
Group #	_____	ID #	_____
Name of Sponsor:	_____	Employer's Name:	_____
Sponsor SSN#	_____	Sponsor DOB:	_____

Billing Information for Private Pay and Speech Therapy:

All payments are due at the time of service(s).

Financial Responsibility:

Individual who is financially responsible for this account:

Name:_____
DOB: _____
SSN: _____

- By signing this form I declare that I am the legal guardian of this minor and allowed by law to make decisions for testing this child. If my insurance or any other information changes prior to the evaluation or during the time my child receives therapy treatment it is my responsibility to provide written changes to ACCESS Speech Therapy, Inc. (ex. new insurance information, home address, phone number, etc.).

- I understand I am financially responsible for services rendered by ACCESS Speech Therapy, Inc., and staff, and I understand that my insurance plan may pay a negotiated portion of these charges. I authorize my insurance company to pay benefits directly to ACCESS Speech Therapy, Inc. I understand that in the event my insurance denies payment for services rendered, for my child, I agree to be personally responsible for those charges. I understand all co-pays designated by the insurance plan contract are my responsibility and are due at the time of my child's office visit. In the event my account is referred to a collection agency for payment, I will be responsible for any fees associated with collection of this debt. In the event my check is returned for insufficient funds, I will be charged a returned check fee of $25.00.

Signature:_____ Date: _____

Attendance Policy:

Since children and other family members understandably get sick, we will allow two cancellations per quarter (three month period). However, if a family needs to cancel additional sessions during this treatment period, payment of a $50.00 cancellation fee is required to keep the child's treatment time on the regular schedule. If attendance becomes an issue with an excessive amount of cancellations, then your child could be in jeopardy of being removed from our daily schedule.

Release of Information:

ACCESS Speech Therapy, Inc. may disclose any or all of the patient's information for insurance claim purposes. If another party is paying the patient's bill, ACCESS may then disclose any or all of the patient's information to that party to verify charges. ACCESS may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and treatment of the patient.

Setting up Initial Evaluation:

As soon as completed paperwork is received at our office, the office manager will contact you to schedule an evaluation. If you have not received a call within one week of returning the paperwork, please contact our office. We look forward to being part of your team!

By signing this form you agree to all the terms and conditions listed above.

Parent/Caregiver
(Please Print Name):_____Signature:_____Date: _____