CHILD CASE HISTORY FORM SPEECH/OT

Child's Name: _____ D.O.B.: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Insurance: _____ ID: _____ SS#: _____

Does the child live with both parents: ____ No ____ Yes

Mother's Name: _____ DOB: _____ SS#: _____

Home Phone #: _____ Cell Phone #: _____

Occupation: _____ Work Phone #: _____

Father's Name: _____ DOB: _____ SS#: _____

Home Phone #: _____ Cell phone #: _____

Occupation: _____ Work Phone #: _____

Pediatrician: _____ Phone #: _____

Sibling #1 Age: _____ Sibling #2 Age: _____ Sibling #3: _____

Who does the child resides with? _____

_____

What is the child's primary language? _____

What languages are spoken at home other than English? _____

With whom does the child spend most of his or her time? _____

PARENTAL AND BIRTH HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

_____

Length of Pregnancy: _____ Length of Labor: _____

Birth Weight: _____ General Condition: _____

Type of Delivery: ____Head First ____Feet First ____Breech ____Caesarian

Were there any unusual conditions that may have affected the pregnancy of birth?

____No ____Yes

If YES please explain: _____

_____

Did child experience any early feeding/swallowing problems (weak suck, turning "blue")

While attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc.)?

_____

_____

Please describe why you are having your child see for a speech-language/occupational evaluation/ therapy.

(e.g. voice, stuttering, expressive/receptive language delay, articulation, reading difficulty, fine motor delays, sensory issues, attention, behavior, homework, writing, etc.)

_____

_____

How does the child usually communicate (gesture, single words, short phrases,sentences)?

_____

_____

How does your child feel and react to his ability to communicate? _____

_____

_____

Has the child receive or is receiving speech or occupational therapy? _____

What type of therapy? _____ Explain where? _____

_____

When was the child seen? _____

What were the specialist's conclusions or suggestions?

_____

_____

Is there any history of any family member with speech and language deficit?

_____No ____Yes

If yes, please include which immediate family member:

1. Speech problems _____
2. Hearing problems _____
3. Autism/Spectrum Disorder _____
4. Seizures/Convulsions _____
5. Learning Disabilities _____

MEDICAL HISTORY

If your child has any history of the following, please explain:

____ there is no history of the following:

____ Ear Infections _____ ____ PE Tubes

____ Frequent colds / sinus infections ____ Bronchitis/Pneumonia

____ Drainage from ear ____ Tonsils/Adenoids removed?

____ Other: _____

Describe any major accidents or hospitalizations: _____

_____

Does child have any medical diagnoses? (e.g., Autism, Dyslexia, Developmental Delay)?

_____

_____

Is the child taking any medications? ____ No ____ Yes, Explain: _____

_____

Does your child have any known allergies? ____ No ____ Yes, If yes identify: _____

_____

DEVELOPMENTAL HISTORY

Yes/No answers. If No, at what age:

Did your child:

____Held his/her head up by 4 months?

____Crawled by 12 months old?

____Walked alone by 16 months old?

____Was potty-trained by 3 years old?

____Sat alone by 12 months old?

____Ate solid food by 12 months old?

____Cooing / Babbling by 4 months old?

____Used scissors by 3 years old?

____ Self-fed by 2 years old?

____Imitate different consonant sounds by 12 months old?

____Respond to his/her name by 8 months old

____Played peek-a-boo by 8 months old?

____Used ***JARGON** by 12-15 months old?

____Said his/her first word by 12 months old?

____Said two words together by 24 months old?

____Used short sentences by 36 months old?

____Grasped crayon/ pencil (thumb finger) by 3 years old?

____Cryed normally (to communicate pain, fear, discomfort, loneliness)?

JARGON is defined as words that are not understandable but are said in "sentences", where the child inflections let you know that he/she is "saying something".

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc.

_____

Please describe your child's fine motor skills while attempting to color, write, draw, and cut with scissors, feed him/herself with utensils, etc.

_____

Has your child hearing been tested previously? ___No ___Yes

If yes, When and what were the results? _____

_____

Does the child respond to sounds (e.g., responds to all sound, responds to loud sounds only, inconsistently responds to sound, etc.) _____

_____

Indicate with a checkmark any items that are difficult for your child:

___Eating variety of foods
___Following directions or routines
___Answering questions
___Speaking in organized or grammatically correct sentences
___Singing songs / reciting nursery rhymes
___Recognizing common words
___ Receiving/giving hugs
___Writing his/her name
___Thinking of words to name objects
___Using a straw
___Understanding concept of time
___Understanding what he/she hears
___Stating sounds of letters
___Pronouncing words correctly
___Rhyming
___Getting his/her point across
___Eye-hand coordinator
___Self-calming
___Keeping shoes on
___Blowing bubbles
___Telling stories
___Keeping hands to him/her

BEHAVIORAL HISTORY

Please check all that describe your child:

___Friendly
___Easy going
___Plays well with other Children
___Attentive
___Poor memory
___Sleeps well
___Impulsive/Impatient
___Difficulty sleeping
___Hyperactive
___Aggressive destructive
___Has temper tantrums
___Willing to try new activities
___Defiant
___Separation difficulties
___Poor eye contact
___Cooperative
___Doesn‘t like to be read to
___Daydream
___Unpredictable
___Eats well

MEDICAL HISTORY

___Will not eat certain textures
___Will not touch certain texture
___Cannot easily shift from one activity to another
___Withdrawn
___Bites nails
___Plays alone for reasonable amount of time
___Doesn‘t like to be touched
___Stubborn Still
___Talkative
___Overly sensitive emotionally
___Bad-tempered
___Has nightmares
___Uses pacifier/sucks thumb
___Grinds teeth
___Clumsy
___Cries easily
___Wets bed
___Easily frustrated
___Distractible/short attention span
___Mouth breather
___Restless
___Shy
___Snores
___Quiet

___Often sensitive to sound

EDUCATIONAL HISTORY

School: _____ Grade: _____ Teacher: _____

How is the child doing academically (or pre-academically)? _____

_____

Does the child receive special services? ___No ___Yes

If yes, describe: _____

_____

How does the child interact with others: (e.g., shy, aggressive, uncooperative, etc.)?

_____

Please provide any additional information that might be helpful in the evaluation or remediation of the child's needs: _____

_____

Person completing form: _____ Date: _____

Signature: _____

Relationship to child: _____

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

AUTHORIZATION AND RELEASE FORM

I, _____, patient/client legally authorize, PLAY PALS THERAPY, INC. to evaluate _____ for speech language pathology/occupational therapy services. I also authorize PLAY PALS THERAPY, INC. to release medical and speech language pathology/occupational therapy records to

_____.

_____ _____

Patient name Date

_____ _____

Parent or legal guardian signature Date

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

TREATMENT AUTHORIZATION

Having a condition requiring diagnostic and treatment, I do hereby voluntarily consent to such diagnostic procedure and treatment by PLAY PALS THERAPY, INC. I am aware that therapy is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment. I have read this form and certify that I understand its full content.

_____ _____

Patient name Date

_____ _____

Parent or legal guardian signature Date

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

PAYMENT POLICY

1. Payment is expected at the time services are tendered, unless other arrangements were made in advance and approved by Director.
2. If services are billed, the terms are “Net 30”, meaning that payment in full is expected within 30 days of the date of the bill.
3. PLAY PALS THERAPY INC., will help in the filling of Insurance claims, but the recipient of services is ultimately responsible for payment of the bill.

_____ _____

Patient name Date

_____ _____

Parent or legal guardian signature Date

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

CANCELLATION POLICY

Due to the overwhelming need for our services, it is our policy to discharge those who are unable to make the necessary commitment to therapy. A client will be discharged after the third “no-show”, (i.e., cancellation not made 24 hours ahead of time), or when attendance has dropped to 50% in any 30-day period.

Unless specifically exempted to do so by law, we reserve the right to charge any cancellations not made by 24 hours ahead of time to your account. You will be fully responsible for paying the charge for non-canceled sessions. Your insurance will not pay for it. If we know you are unable to attend your session in advance, we can make the necessary adjustments to our schedule.

_____ _____

Patient name Date

_____ _____

Parent or legal guardian signature Date

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

NO SHOW FEE

IMPORTANT NOTICE FOR ALL PATIENTS

Effective Immediately…

Every day there are patients who do not show up for their appointments.

That creates a problem for other patients, who want to come in sooner and can't due to the lack of open slots on the schedule, and for the office.

This is why we will charge you a $25.00 "**No Show Fee**". If you don't call in advance to cancel or reschedule if you can't make it to your appointment.

Please be considerate with other patients, the office and call at least 24 hours in advance if you are not coming.

I understand that I will be charged with a "No Show" fee in the amount of $25.00, this fee will be collected prior to being seen in your next scheduled appointment.

Thank you,

Patient Name: _____

Parent or legal guardian signature: _____

DATE: _____

PARENTS, IF YOU SIGNED THE CANCELLATION POLICY, THERE WILL BE A $25.00 FEE FOR EACH MISSED THERAPY SESSION FOR NOT SHOWING UP OR FOR NOT CANCELING 24 HOURS BEFORE.

_____

Parent or Legal Guardian Signature

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

¡NOTICE!

There is nothing more important than the well-being of your children. Family Care focuses on the needs of the child and their family context. Families are seen as active participants in their child's therapy and are not excluded from the process.

We thank you and request that every child who receives therapies at our center CANNOT STAY ALONE at any time during the process of receiving their therapies.

<u>Parents should wait for their children in the waiting room.</u>

Thank you.

The Management reserves the right of admission.

_____

Parent or Legal Guardian Signature

PLAY PALS THERAPY

1428 Sunrise Plaza Dr. Suite 3
Clermont, FL 34714
Telephone: (352) 301-7535 / Fax: (352) 275-5024
playpalstx@gmail.com

I, _____, hereby grant 'Play Pals Therapy LLC' permission to take and publish photographs and videos of myself and my child for any lawful purpose, including, but not limited to, their website, social media accounts and promotional material, either digital or in print, in perpetuity. I _____ deny permission to use my name or any other personal information.

By signing and dating this document I authorize 'Play Pals Therapy LLC' to edit, alter, share, remix, tweak, build upon or in any way alter the photograph/video(s) mentioned above. I also wave any rights of privacy or compensation associated with the use of my image(s) for the commercial purposes outlined above.

Yo, _____, por la presente otorgo permiso a 'Play Pals Therapy LLC' para tomar y publicar fotografías y videos de mí y de mi hijo para cualquier propósito legal, incluidos, entre otros, su sitio web, cuentas de redes sociales y material promocional, ya sea digital o en forma impresa, a perpetuidad. Yo _____ niego el permiso para usar mi nombre o cualquier otra información personal.

Al firmar y fechar este documento, autorizo a 'Play Pals Therapy LLC' a editar, alterar, compartir, remezclar, modificar, desarrollar o alterar de alguna manera las fotografías / videos mencionados anteriormente. También renuncio a cualquier derecho de privacidad o compensación asociado con el uso de mi(s) imagen(s) para los fines comerciales descritos anteriormente.

_____ _____

Patient/Parent or Legal Guardian Signature **Date**