Speech Solutions Speech and Language Therapy
INITIAL FORM - PATIENT DATA
Please return PRIOR to your child's first appointment

CONTACT INFORMATION	
Child's Name:	Date of Birth:
Parents/Guardian:	Child's Chronological Age:
Parents/Guardian:	Home Telephone:
Address:	Cell Phone:
City, ST, Zip:	E-mail Address:
Male or Female:	Referred by:

MEDICAL INFORMATION
Physician's Name:
Allergies/Special Health Considerations:

INSURANCE INFORMATION
A superbill will be provided at the time of service, and it is the responsibility of the Insured to submit a claim for payment. This practice does not bill or coordinate directly with insurance. Assignment of benefits is to family not therapist as this is a private pay practice. All ICD-10 Diagnostic codes and CPT treatment codes will be provided on the superbill to submit to insurance for family reimbursement.

Name of Insurance Company:
Are codes 92523 & 92507(treatment) covered?:
Are there any limitations to coverage, such as having to be a "medical condition"?:
Is a Preauthorization required?:
Speech & Language treatment sessions allowed per year:

CASE HISTORY FORM

Family Information

Child's Name:

Specialists/OT/PT/: Contact Information:

Pediatrician's Name: Contact Information:

Mother's Name: Phone Number:

Mother's Occupation: Email:

Father's Name: Phone Number:

Father's Occupation: Email:

Child lives with (check one):

❑ Birth Parents ❑ Adoptive Parents ❑ Foster Parents ❑ Parent and Stepparent ❑ One Parent ❑ Other

Other children in the family:

Name: Age: Speech & Language Delay (if yes, please describe)

_____ ❑ Yes ❑ No _____

_____ ❑ Yes ❑ No _____

_____

_____ ❑ Yes ❑ No _____

Other delays (please check):

❑ Autism / Family Member_____

❑ Receptive-Expressive Language Delay / Family Member_____

❑ Speech (articulation delay) _____

❑ Fluency (stuttering) _____

❑ ADHD / Family Member_____

❑ Behavioral Challenges / Family Member_____

Is there a language other than English spoken in the home? ❑Yes ❑No. **Name of Language**:_____

Does the child speak the language? ❑ Yes ❑ No Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

PREGNANCY & DELIVERY

Was there anything unusual about pregnancy or birth? ❑ Yes ❑ No If yes, please describe.

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.

DEVELOPMENTAL MILESTONES

Please tell the approximate age your child achieved the following developmental milestones or note typical or delayed.

SKILL	AGE ACQUIRED or Typical/Delayed
Walked	
Babbled	
Said first words	
Put two words together	
Spoke in sentences	

Please describe your speech and language concerns:

_____

_____

Please describe any behavioral concerns you may have:

_____

_____

PREVIOUS EVALUATIONS

Has he/she ever had a speech and/or language evaluation/screening? ❑ Yes ❑ No

Where & When?

Do you have a current or previous speech report or assessment? ❑ Yes ❑ No

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Has he/she had a hearing screening? ❑ Yes ❑ No **Results:** ❑ Passed ❑ Did Not Pass

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Has your child ever had speech therapy? ❑ Yes ❑ No

Where & When?

Does your child receive speech therapy at school? ❑ Yes ❑ No

Has your child received any other evaluations or therapy (PT, OT, ABA, etc.)? ❑ Yes ❑ No

Where and When:

MEDICAL / OTHER

Is your child aware of, or frustrated by, any speech/language difficulties? ❑ Yes ❑ No

Please list any medications your child takes regularly:

Does your child:

❑ repeat sounds, words or phrases when asked?

❑ retrieve/point to common objects upon request (ball, cup, shoe)?

❑ follow simple familiar 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) – approximately how many words clearly: _____

❑ 2-to-4-word sentences.

❑ sentences longer than four words.

Behavioral Characteristics:

❑ cooperative

❑ attentive

❑ willing to try new activities

❑ plays alone for reasonable length of time

❑ separation difficulties

❑ easily frustrated/impulsive

❑ stubborn

❑ restless

❑ poor eye contact

❑ easily distracted/short attention

❑ destructive/aggressive

❑ withdrawn

❑ picky eater (limited textures)

❑ good sleeper

❑ walks on toes often

❑ fearless

❑ sucks his/her thumb

❑ uses pacifier

❑ falls frequently / unaware of surroundings

❑ flaps hands when excited or other times

❑ looks at toys in a horizontal position on the floor

❑ sensitive to loud noises

❑ tantrums longer than 30 minutes each day

❑ has difficulty transitioning

If your child is in school, please answer the following:

Name of school and grade in school: _____

Days/Times attends school: _____

Does your child have an IEP? ❑ Yes ❑ No

If yes, what services is your child currently receiving?
(please provide us with a copy of his/her IEP) _____

_____

_____

_____

Check / List preferred play activities:

❑ Cars, trains, planes, etc.

❑ Cause-Effect play

❑ Bubbles, wind-up toys, shape sorters, etc.

❑ Farm animals

❑ Pretend Kitchen play

❑ Coloring / Fine motor activities

❑ Going to the park, swinging, sliding, climbing, etc. (gross motor activities)

❑ My child really likes the characters (i.e., Mickey, Cars, Princesses, etc.) : _____

❑ Other Interests: _____

Additional Information you would like to share:

_____

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