BILINGUAL SPEECH-LANGUAGE
PATHOLOGY CENTER, INC.

3049 Cleveland Ave # 275 Ft. Myers, FL 33901
Tel: 239-479-5093 - Fax: 239-479-5094

CASE HISTORY

Date:_____/_____/______

Child's Name:____

Date of Birth: ______/______/______ Age: ______________________

Address: ____

City:__________________________________ Zip Code: __________

Home Phone: (_____)_______-________

Mother's Name: ____

Work Phone: (_____)________-________ Cell: (_____)______-_________

Father's Name: ____

Work Phone: (_____)________-________ Cell: (_____)______-_________

Primary Care Physician/Pediatrician: ____________________________

Referred By: ____

What concerns you regarding this child: __________________________

____

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Child's Name:____

I. Birth/Medical History:

A. Your Child Primarily communicates through which of the following?

__Physically directing __gestures __pointing __Babbling __Single Words __Phrases __Sentences

Pregnancy was ___Weeks Labor/Hours: ____ Weight: ___Length: ___

Method of delivery: __Natural __C-Section, reason:___________________________________

B. Any Difficulty prior to birth? __Yes __No
If Yes, please explain:____

C. Any difficulty at the time of birth? __Yes __No
If Yes, please explain:____

D. Any difficulty after birth? (e.g. hospitalization, procedures, etc.) __Yes __No
If Yes, Please explain:____

E. Is your child taking any medications at this time? __Yes __No
If Yes, Please List:____

II. General Health:

A. Has your child experienced:

1. High Fevers __Yes __No
2. Seizures/Fainting/staring spells __Yes __No
3. Visions problems __Yes __No
4. Allergies __Yes __No Explain:____
5. Ear infections __Yes __No Frequency:____________________________________
6. Frequent colds or sore throats __Yes __No
7. Mouth breathing __Yes __No
8. Removal of tonsils and/or adenoids __Yes __No When:______________________
9. Feeding problems (e.g. chewing, swallowing) __Yes __No
   Explain:____

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III. Developmental History:

Developmental Milestones:

A.Age sat alone: ________________________________ months.
B.Age walked alone: _____________________________months.
C.Time period for toilet training? ____
D.Child's physical development has been: __Fast __Normal __Slow
E.Coordination __Good __Clumsy

Speech-Language Developmental History:

A. Language(s) spoken at home/language(s) child is exposed to:____________________________
B. When were you first concerned about your child's speech or hearing difficulty?
____
C. Is your child responsive to sound or voice? __Yes __No
D. When did your child begin to: Babble? ________________ Use single words? ________________
Combine 2 3 words? ___________________________ Use simple sentences? _________________
E. By whom is child understood?
By Family? __Yes __No By Strangers? __Yes __No Other Children? __Yes __No
F. Does your child have trouble understanding the speech of others? __Yes __No
Explain:____
G. Does any other member of the family have speech or hearing difficulties? __Yes __No
Explain:____
H. Learning/academic problem? __Yes __No
Explain: ____
I. Has your child ever been seen for a speech language/hearing evaluation? __Yes __No
Where? ____

IV. Family Status:

A. Check all person living at home:
__ Mother __Father __ Siblings __Other:____
B. Father's Occupation:____ Age: _________
Mother's Occupation: ____ Age: _________
C. Please List siblings and information below:

Name	Age	Sex	School	Grade Reached

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Child's Name:____

D. Who cares for your child throughout the day? ____
Language they use? ____

V. Educational Status:

Childcare/Daycare

A. Name of School your child attends: ____
B. Grade: _______________ Teacher: ____

VI. Behavioral Status:

A. Behavioral (mark any of the following that describes the behavior of the child):

__ Easily managed
__ Nightmares
__ Temper tantrum
__ Thumbsucker
__ Very Active
__ Good eye contact
__ Poor eye contact
__ Shy
__ Slow learner
__ Plays well with playmates
__ Has no playmates
__ Prefers to play alone
__ Nervous
__ Demands excessive attention
__ Overly Talkative
__ Jealous
__ Destructive
__ Likes School
__ Behavior problem
__ Unusual Fears

VII. Additional Comments: (If there is any information that you would like for us to know about your child that is not already listed in this form, please feel free to describe below)

Describe:____
____
____
____
____
____
____
____
____

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Child's Name:____

FINANCIAL POLICY

Thank you for choosing our center. We are committed to your treatment being successful.
Please understand that payment of your bill is considered an integral part of your treatment.
The following is a statement of your Financial Policy, which we require you to read and sign.
Please fill out all forms and submit your Driver's License for copying.
FULL PAYMENT IS DUE AT TIME OF SERVICE.
The undersigned agrees, whether he/she signs as guardian, agent, or as patient, that is in considerations of the services to be rendered to the patient, that he/she hereby individually obligates himself/herself to pay for the account of Bilingual Speech-Language Pathology Center, Inc. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Patient's Name: ________________________________ Parent's Name: ____________________
Parent's S.S. #: ______-____-________ Parent's D.L. #: __________________________________
Signature: ______________________________ Date: ________ Relationship: ________________

ATTENDANCE POLICY

Due to the great demand for our services, our attendance policy is as follows:
* We try to be punctual and we expect the same from you. If you are late, we may not be able to provide the full therapy session.
* If you are unable to attend your treatment session, we expect you to call as soon as possible and reschedule your appointment.
* Three unexcused absences will result in the patient's removal from our schedule. You will then have to re-establish treatment at another time.

Patient's Name: _______________________ Relationship: _________________
Signature: ___________________________ Date: ______________________

MEDICAL RECORDS RELEASE OF INFORMATION POLICY (HIPAA)

I received a copy of Bilingual Speech-Language Pathology Center, Inc.'s Notice of Privacy Practices with an effective date of April 14, 2003.

Signature: ____ **Date**: _____________

I, as parent or guardian of ___________________________________, authorize Bilingual Speech-Language Pathology Center, Inc. to obtain/release medical records from/to any institution or other professionals as deemed necessary.

Signature: ____ **Date**: _____________

I give permission for our child, _______________________________ to receive services by the speech-language pathologist/assigned to him/her.

Signature: ____ **Date:** _____________

I authorize my child, ______________________________ to be observed by students in the field of Speech/Language Pathology/Education.

Signature: ____ **Date:** _____________