Yardley Speech and Language

103 Eton Rd., Yardley, PA 19067

215-428-2777

www.yardleyspeechandlanguage.com

PEDIATRIC INTAKE FORM

Please answer the following questions about your child's history. Please attach copies of the following documents:

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations.
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST AT YOUR EARLIEST CONVENIENCE.

GENERAL INFORMATION				
Full Name			**Gender**	**DOB**
Current Age		**School**		
Street Address			**City**	**ZIP**
Parent/ Guardian Cell Number		**Is it OK to send you texts?** YES NO	**Email Address**	
Pediatrician	**Name/Address**			**Pediatrician Phone**
How did you learn about Yardley Speech and Language?				
Emergency Contact	**Name**		**Relation to Child**	**Phone**

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SPEECH/LANGUAGE BACKGROUND	
At what age did your child begin to babble?	
When did he/she start to use single words that consistently meant something?	
When did he/she begin to put two words together?	
How old was your child when he/she started to speak in short sentences?	
Has your child said words once and then never again?	
Does your child use gestures more than words to communicate?	
Does your child have difficulty following directions?	
Does anyone have difficulty understanding your child's speech?	
Has the problem changed since it was first noticed? How?	
Has your child seen any other speech-language pathologists? If yes, when and for how long?	
What were their conclusions or suggestions?	
Please describe your concerns regarding your child's communication skills? What are your goals for your child's speech-language services?	

Patient Name: ___________________________

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FAMILY INFORMATION			
With whom does the child live?	Name	Relation to Child	Age

Has anyone in your family experienced speech/ language/ learning problems?	Relationship to Child	Nature of the Difficulty
Are any languages other than English spoken in the home? Which ones, and who speaks them?		

SOCIAL BACKGROUND	
Do you think your child's communication problem has impacted his/her social interactions with peers?	
How does your child react to his/her communication difficulties?	
How do family members react to your child's communication difficulties?	
Describe how your child plays with other children.	

SOCIAL BACKGROUND		
Does your child engage in an activity for a reasonable length of time? What if it's a new activity?	YES NO	Explain, if necessary.
Does your child become easily frustrated?	YES NO	
Does your child separate from you easily?	YES NO	
Does your child have extreme fears?	YES NO	
Does your child have frequent tantrums?	YES NO	

EDUCATIONAL BACKGROUND			
Does your child attend daycare?	YES NO	Where?	How many days per week?
If your child is in school, what grade is he in?	Grade?	Where?	
What are the teachers reporting to you regarding academics, socialization, and speech/language?			
Does your child like school/daycare?	YES NO		

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HEALTH BACKGROUND			
Has your child's hearing been tested recently?	Date	Provider	Results
Has your child's vision been tested recently?	Date	Provider	Results
Were there any problems during pregnancy? Please describe.			
Was labor full term?	Yes No		
Were there any problems with delivery? Please describe.			
Please place a check mark to indicate when the following motor milestones were achieved.	Early	Typical	Late
Sitting up			
Crawling			
Walking			
Running			
Potty Training (Day)			
Potty Training (Night)			
Please describe any serious illnesses, injuries, or medical procedures your child has experienced. Include approximate dates and durations.			
Has he/she ever been hospitalized?	Dates	Reason	

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HEALTH BACKGROUND			
Please describe any problems with your child's teeth, tongue, mouth, ears, nose or throat.			
Describe any difficulties with eating, swallowing, chewing, textured foods, etc.			
Describe any other conditions or diagnoses your child has had or currently has that may not be considered, "serious."			
List any environmental or food allergies.			
List any current medications and their purposes.			
Has your child ever been referred to any of the following specialists? Please circle.	TYPE Otolaryngologist (ENT) Gastroenterologist Psychologist Psychiatrist Occupational Therapist Physical Therapist Developmental Ped.	PROVIDER	DATE
Please explain reason and results of these specialist consults.			
Would you consider your child to be generally well coordinated?	YES NO		

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HEALTH BACKGROUND			
Is your child right or left handed?			
Is your child particularly sensitive to anything, such as textures, noises, etc?			

ADDITIONAL INFORMATION			
Please list your child's favorite activities.			
Please provide any additional information that might be helpful in the evaluation or remediation process.			

Full name of person completing this history form:			
Relationship to Patient			
Signature		Date	

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CONSENT OF TREATMENT FOR MINOR CHILD

I hereby authorize Jennifer Niemeyer, M.S. CCC-SLP to provide speech/language therapy to my minor child. I further authorize the following adults (over age 18) to act as my agent when presenting my minor child for speech-language therapy, and assign authority to them to allow treatment, including therapy and evaluations.

____________________________ ____________________________

DATE PARENT / GUARDIAN NAME (please print)

____

PARENT / GUARDIAN SIGNATURE

_______________________ ____________ _________ ________

PRINTED NAME OF AGENT RELATIONSHIP Parent Initials Date

_______________________ ____________ _________ ________

PRINTED NAME OF AGENT RELATIONSHIP Parent Initials Date

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to Jennifer Niemeyer, M.S. CCC-SLP for all charges. I also understand that payment is due at time of service and that a fee may be charged for any missed appointment not canceled prior to 24 hours before the scheduled session.

I authorize Jennifer Niemeyer, M.S. CCC-SLP to release medical information to my insurance for services rendered to my minor child (dependent) as may be necessary for payment of Jennifer Niemeyer, M.S. CCC-SLP claims.

____________________________ ____________________________

DATE PARENT / GUARDIAN NAME (please print)

____

PARENT / GUARDIAN SIGNATURE

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize the release of medical and/or speech and language information for my minor child necessary for the use of speech/language therapy of the child to Jennifer Niemeyer, M.S. CCC-SLP including test results, treatment, therapy and other medical management for payment, authorizations and Quality reviews.

____________________________ ____________________________

DATE PARENT / GUARDIAN NAME (please print)

____

PARENT / GUARDIAN SIGNATURE

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If you have designated agents authorized to present your child for care and to authorize treatment, do you give permission for the same agent to receive medical information? **YES NO**
Parent / guardian initials ________

If we are trying to contact you with medical/speech/language treatment information and reach voicemail, do you authorize us to leave a detailed message on that voicemail? YES NO Can a text message regarding your child's case be left on your cell phone? **YES NO**
Parent / guardian initials ________

IF YOU SELECT "NO" WE WILL ONLY LEAVE A MESSAGE THAT WE CALLED AND YOU WILL NEED TO RETURN OUR CALL.

Do you authorize use of voice or text messaging with your agents that contains medical/speech/language treatment information? **YES NO**
Parent / guardian initials ________
NOTE: We may also disclose PHI to your child's other health care providers when such PHI is required for them to treat him/her, receive payment for services they render to him/her, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. We may use your child's PHI for purposes of calling your home or alternate location and leaving a message or voice mail or in person in reference to any calls pertaining to his/her clinical care, including test results among others, unless or until revoked by you in writing. We may mail to your home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, unless or until revoked by you in writing.

________________________________ ________________________________
DATE PARENT / GUARDIAN NAME (please print)

____
PARENT / GUARDIAN SIGNATURE

Do you give consent for your child to be audio/video recorded for clinical use only, to be used for evaluation and treatment your child? **YES NO**
Parent / guardian initials ________

Patient Name: ________________________