**Speech Therapy on the Go! LLC.**

 **Phone: 954-540-4808 Email: STontheGo@aol.com Fax: 1-888-232-1831**

**Initial Intake Form**

**PATIENT INFORMATION**

|  |  |
| --- | --- |
| Name | First: Last: |
| Date of Birth |  Gender: M / F |
| Address |  |
| City, State, Zip |  |
| Home Phone |  |
| Phone/Email/Fax |  |
|  |  |
| Pediatrician’s Name |   |
| Pediatrician’s Address |  |
| Other Professionalsseeing your child? | Speech Therapist, Occupational therapist, Physical therapist, Psychologist, Nutritionist? |
| Name/Service |  |
| Phone: |  |
| Name/Service |  |
| Phone: |  |
| School/Pre-School |  |
| Medical Diagnosis |  |

**PARENT INFORMATION**

|  |  |
| --- | --- |
| Mother/Guardian |   |
| Place of Employment |  |
| Phone Number | Hm: Cell: |
| Father/Guardian |   |
| Place of Employment |  |
| Phone Number | Hm: Cell: |

Whom may we thank for referring you?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSIS INFORMATION**

|  |  |
| --- | --- |
| Primary Diagnosis |  |
| Secondary Diagnosis |  |
| Describe Concern (s) |  |
| Primary Language | **Home: School:** |
| **Expressive Language:****How does your child communicate?**  | **Gestures? Words? Phrases? Sentences?** |
| **Receptive Language/****Central Auditory Processing Disorder** |  |
| **Speech/Intelligibility** **Articulation** |  |
| **Fluency/Stuttering** |  |
| **Oral Motor/Apraxia** |  |
| **Reading Difficulties** |  |
| **Pragmatic Language** |  |

**PRENATAL/BIRTH HISTORY**

|  |  |
| --- | --- |
| **History of pregnancy** |  |
| **Length of pregnancy** | **Full Term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks gestation** **Premature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks gestation**  |
| **Type of Delivery** | **Natural C-Section Breech** |
| **Any complications of labor/delivery?** |  |

**DEVELOPMENTAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Present Level of Activity** | **Active** | **Typical** | **Low Arousal** |
| **Developmental Milestones****List the approx. age** | **Sat Alone** | **Crawling** | **Walking** |
|  | **Running** | **Babbling** | **First Words** |
|  | **Sentences** | **Cup drinking** | **Straw drinking** |
| **Toilet Trained** | **Yes** | **No** | **Age:** |
| **SPEECH/LANGUAGE** |  |  |  |
| **Was your infant** | **A quiet baby?** | **Yes** | **No** |
|  | **Frequent crier?** | **Yes** | **No** |
|  | **Irritable?** | **Yes** | **No** |
|  | **Visually alert?** | **Yes** | **No** |
|  | **Alert to sounds?** | **Yes** | **No** |
| **Did your child begin to talk or babble and then stop?** | **What age?** | **Yes** | **No** |
| **Presently, does your child have…….** | **Intelligible speech** | **Yes** | **No** |
|  | **A loud voice?** | **Yes** | **No** |
|  | **A hoarse voice?** | **Yes** | **No** |
|  | **A soft voice?** | **Yes** | **No** |
|  | **A monotone voice?** | **Yes** | **No** |
| **Does your child…..** | **Respond negatively to loud sounds?** | **Yes** | **No** |
|  | **Ignore sounds** | **Yes** | **No** |
|  | **Respond to sounds** | **Yes** | **No** |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **Current Medications** |  |
| **Significant illness or infections and dates.** |  |
| **Ear Infections?****Chronic?** **List approximate # of infections and dates.** |  |

**MEDICAL HISTORY CONTINUED**

|  |  |
| --- | --- |
| **List all allergies.****Food, Non-Food and Medications** |  |
| **List significant surgeries and approximate dates.** |  |
| **List hospitalizations and approximate dates.** |  |

**EDUCATIONAL BACKGROUND**

|  |  |
| --- | --- |
| **School/Grade** |  |
| **School Address** |  |
| **City, State, Zip** |  |
| **School Phone** |  |
| **Teacher’s Name** |  |
| **Academic concerns?** |  |

**PERSONALITY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Is your child** | **Quiet, calm, relaxed, patient?** | **Y** | **N** |
|  | **Active, outgoing, enthusiastic?** | **Y** | **N** |
|  | **Intense, demanding?** | **Y** | **N** |
|  | **In perpetual motion all the time?** | **Y** | **N** |
|  | **Upsets easily when there are changes in the daily routine?** | **Y** | **N** |
|  | **Passive, quiet, withdrawn?** | **Y** | **N** |
|  | **Rigid, set in his/her routine?** | **Y** | **N** |
|  | **Has regular sleep patterns?** | **Y** | **N** |
|  | **Demonstrates difficulty going to bed/falling asleep?** | **Y** | **N** |
|  | **Demonstrates difficulty waking up?** | **Y** | **N** |
|  | **Is able to sit and attend for a lengthy amount of time?** | **Y** | **N** |
|  | **Unable to attend to for even a short amount of time?** | **Y** | **N** |
|  | **Avoids trying new things, overly cautious?** | **Y** | **N** |
|  | **Destructive with toys?** | **Y** | **N** |
|  | **Jumps off furniture, has no regard for safety?** | **Y** | **N** |
|  | **Demonstrates difficulty maintaining own personal space?** | **Y** | **N** |
|  | **Organized, has a place for everything?** | **Y** | **N** |
|  | **Disorganized, has difficulty keeping school work organized?** | **Y** | **N** |
| **Comments****or** **Concerns?** |  |  |  |

**EVALUATIONS:**

**If your child has not had a resent evaluation (within 6 months), an evaluation is required to develop a treatment plan. If you plan to bill your insurance company for the evaluation, a prescription from your pediatrician is needed prior to setting up an appointment for a speech-language evaluation.**

**I have read and fully understand the above statement.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Child’s name Date**

**INSURANCE INFORMATION**

|  |  |
| --- | --- |
| **Name of Insurance** |  |
| **Name of Insured** |  |
| **ID #** |  **Group #** |
| **Member Services** | **Phone #:** |
| **Relationship to Insured** |  |

**ASSIGNMENT AND RELEASE**

**I, the undersigned, understand that I am financially responsible for all charges incurred whether or not I am using my insurance coverage and/or what is not paid for by my insurance. I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to Amanda Foutch/Speech Therapy on the Go! LLC. all insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party’s Signature Relationship Date**

**ATTENDANCE POLICY**

**I agree to give at least 24 hours notice when canceling a set appointment. In the event that I do not give this advanced notice, I agree to pay a 50% surcharge based on the set fee for the scheduled therapy time. In the case of an emergency, I will notify the speech-language pathologist as soon as possible and make arrangements to reschedule the appointment.**

**If 75% of appointments are missed in any given month, dismissal from therapy may result.**

**I further acknowledge that if I arrive late for my scheduled appointment time, the speech-language pathologist may not be able to accommodate the total treatment time and charges for the pre-scheduled therapy time will be billed in full. We realize that circumstances beyond our control do come up at times, however, we cannot make the next client wait for their treatment session.**

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**Parent/Guardian Signature Date**

**PAYMENT POLICY**

**Payment for therapy services provided will be due either bi-weekly or monthly, please make your payment or co-payment upon receipt of your invoice. If payment cannot be made within 5 business days, Amanda Foutch must be contacted so arrangements can be made. Failure to make payments within 10 business days will result in suspension of therapy services.**

**I have read and fully understand the above statement.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**