SPS

Speech Pathology Services

PATIENT INFORMATION & CONSENT FORM

Patient Information
Patient Name _____
Address _____ City _____ State____ Zip Code_____
Work # _____ Home # _____ Cell # _____
Date of Birth _____ Sex M__ F__ Social Security #_____

Insured Information
Name _____
Address _____ City _____ State____ Zip Code_____
Work # _____ Home # _____ Cell # _____
Date of Birth _____ Sex M__ F__ Social Security #_____

Insured Employment Information
Employer _____
Address _____ City _____ State____ Zip Code _____

Insurance Information
Primary _____
Address _____ City _____ State ____ Zip Code _____
Phone # _____ Policy #_____ Group #_____
Secondary _____
Address _____ City _____ State ____ Zip Code _____
Phone # _____ Policy #_____ Group #_____

Referring Physician/Referral Source _____
Referral # _____ Date of Recheck _____
Reason for visit _____
Is this injury or condition related to work _____ auto accident _____? Date of Illness _____

Personal Information
Type of Work _____ Education/Schooling_____
Married Y__ N__ Spouse's name _____ # of years _____
Children Y__ N__ Names & Ages _____

Speech Pathology Services does not accept credit cards.

I hereby authorize my insurance company to pay directly to _____ medical benefits otherwise payable to me and I will be responsible to said _____ for all expenses incidental to treatment rendered not paid under this plan.

Patient _____ Date_____
Guardian (if required) _____ Date_____

12700 Hillcrest Road, Suite 276, Dallas, Texas 75230

Section I: Background Information

Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Referring Physician: _____ Next Appointment: _____

Major Complaint: _____

_____

Age problem was first noticed: _____ Who first noticed the problem? Under what circumstances?

_____

Have you noticed any change since then? If yes, please describe: _____

_____

How severe is the problem now? Does the problem vary at all from day to day? If it does vary, what do you think causes the changes? _____

_____

What do you think caused the problem? _____

_____

Have you gotten any help for this problem? If so, by whom and what was the treatment? _____

_____

Did this treatment result in any change? Please describe: _____

_____

Section II: Please answer by filling in the blanks or circling answers which apply to your child.

•Is your child able to understand what is said to him/her? Most of the time/Some of the time/None of the time

•At the present time, how does your child tell you what he/she wants? _____

•Please give the approximate age at which your child began to use:

Sounds _____ Single words _____ Two word phrases _____ Short sentences _____

• Is your child talkative: at home/ with strangers/ with playmates

•Is your child's speech development slower than/ similar to/ faster than other children his/her age?

•Are you aware of any speech or language problems among family members or friends? Please describe:

_____

•Is a language other than English spoken in your home? If so, which language? _____

•Which language is used most frequently at home? _____

•Does your child speak any language other than English? If so, which language did he/she learn to speak first? _____

•At approximately what age did your child do each of the following:

Sit alone _____ Crawl _____ Walk _____ Self feed _____

•Did you consider your child's development of these skills slower than/ similar to/ faster than the development of other children his/her age?

•Has your child had any problems in the following areas?

Sleeping/ Feeding/ Excessive crying/ Rocking in bed/ Bedwetting/ Thumb sucking/ Other: _____

•Does your child usually play alone/ with younger children/ with children of the same age/ with older children?

•Describe your child's play activities: _____

• What is your child's current grade and school placement? _____

Section III: Health

•What is your child's current health condition? Excellent/ Good/ Poor

•Is he/she currently taking any medication? If so, please describe: _____

_____

•Has your child had any of the following diseases? If so, please indicate approximate age.

Asthma _____	Hay Fever _____	Adenoidectomy ____	Mumps _____
Pneumonia _____	Whooping Cough ____	Polio _____	Meningitis ____
Tonsillitis _____	Scarlet Fever _____	Measles _____	Ulcers _____
Chicken Pox _____	Convulsions _____	Frequent Colds or Sore Throats _____	
Rheumatic Fever ____	Head Injury _____	Earaches _____	

Other: _____

•Has your child had any complications with the above diseases (high fever, prolonged recovery period, etc.)? If so, please describe: _____

•Has your child ever been hospitalized? If so, please give approximate dates and age as well as the reason for the hospitalization. _____

•Has your child had his/her hearing tested? If so, when and what were the results? _____

•Have tubes been placed in the ears? If so, when and by which doctor? _____

•Does your child currently wear glasses? _____

•Has your child had any special dental problems? If so, please describe: _____

•Has your child had a psychological evaluation? If so, when and with whom? _____

•Has your child had any surgeries in the past ten years? If so, please describe and give approximate dates for each.

_____

_____

Section IV:

•With whom does your child live? _____

•Please list the members of the household in order of age beginning with the oldest (including mother and father):

Member	Age	Sex	Current Grade in School

•If there is any other information you feel might be helpful in understanding your child, please write below:

_____

_____

_____

_____

•Please give the name and addresses of professional personnel requesting a report of this evaluation:

Name: _____ Title: _____ Phone: _____

Address: _____

Name: _____ Title: _____ Phone: _____

Address: _____

Name: _____ Title: _____ Phone: _____

Address: _____