

# 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 \_\_\_\_\_

**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: \_\_\_\_\_

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- 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):

<u>Member</u>	<u>Age</u>	<u>Sex</u>	<u>Current Grade in School</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

•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: \_\_\_\_\_