



Child Case History Form (Dyslexia)

GENERAL INFORMATION:

Date: ___/___/___ Date of Birth: ___/___/___ Age: _____

Child's Name: _____

Child's Social Security Number _____ - _____ - _____

Daycare or school child attends: _____ Grade: _____

Mother's Name: _____

Mother's Profession: _____ Social Security Number ___ - ___ - ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Cell: (____) _____ E-mail: _____

Father's Name: _____

Father's Profession: _____ Social Security Number ___ - ___ - ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Cell: (____) _____ E-mail: _____

How did you hear about us?

___ **Internet** (Name of Site) _____

___ **Phone Book** (Which Phonebook) _____

___ **Professional** (Please Name) _____

___ **Friend/Relative** (Please Name) _____

___ **Other** (Please Explain) _____

FOR OFFICE USE ONLY

Testing Date(s) _____

MEDICAL HISTORY:

Child's allergies: _____

Primary care physician: _____

Referred by: _____

Reason for today's visit: _____

When did your child last see a dentist? _____

When was your child's vision last tested? _____

Results of those tests: _____

Has your child ever had ear infections? If so, how often? _____

How was it treated? _____

Has your child ever had tubes? If so, when? _____

When was your child's hearing last tested? _____

Results of those tests: _____

Please list current and past medical problems, surgeries, illnesses, diseases, and injuries with dates of occurrences: _____

Please list any regularly prescribed medications:

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Child's birth weight: _____

What was your child's APGAR score? _____

Describe any problems at birth (*i.e., respiratory distress, congenital birth defects, etc.*):

Describe all medical conditions, medications given, or special medical treatments following birth: _____

Hospitalized in: ___ Regular Nursery ___ Special Care Nursery

Length of Stay in: ___ Regular Nursery ___ Special Care Nursery

Reason for extended hospital stay (if applicable): _____

Did/does your child display any of the following signs? (please explain):

PRE-SCHOOL:

YES /NO Delayed Speech _____

YES /NO Mixing up the sounds and syllables in long words _____

YES /NO Chronic ear infections (list number) _____

YES /NO Severe reactions to childhood illnesses _____

YES /NO Constant confusion of left versus right _____

YES /NO Late establishing a dominant hand _____

YES /NO Difficulty learning to tie shoes _____

YES /NO Trouble memorizing their address, phone number or alphabet _____

YES /NO Can't create words that rhyme _____

YES /NO A close relative with Dyslexia _____

ELEMENTARY SCHOOL:

YES /NO Dysgraphia (slow, non-automatic handwriting that is difficult to read) _

YES /NO Letter or number reversals continuing past the end of first grade _____

YES /NO Extreme difficulty learning cursive _____

YES /NO Slow, choppy inaccurate reading: _____

Guesses based on shape or content _____

skips or misreads prepositions (at, to of) _____

ignores suffixes _____

skips lines _____

can't sound out unknown words _____

YES /NO Terrible spelling _____

YES /NO Often can't remember sight words (they, were, does) or homonyms _____

(their, they're and there) _____

YES /NO Difficulty telling time with a clock with hands _____

YES /NO Trouble with math _____

Memorizing multiplication tables _____

Memorizing a sequence of steps _____

Directionality _____

YES /NO When speaking, difficulty finding the correct word _____

Lots of "whatyamacallits" and "thingies" _____

Common sayings come out slightly twisted _____

YES /NO Extremely messy bedroom, backpack, and desk _____

YES /NO Dreads going to school _____

Complains of stomach aches or headaches _____

May have nightmares about school _____

HIGH SCHOOL:

YES /NO Limited vocabulary _____

YES /NO Extremely poor written expression _____

Large discrepancy between verbal skills and written compositions _____

YES /NO Unable to master a foreign language _____

YES /NO Difficulty reading printed music _____

YES /NO Poor grades in many classes _____

YES /NO May drop out of high school _____

ADULT-HOOD:

YES /NO Slow reader _____

YES /NO May have to read a page 2 or 3 times to understand it _____

YES /NO Terrible speller _____

YES /NO Difficulty putting thoughts onto paper _____

Dreads writing memos or letters _____

YES /NO Still has difficulty with right versus left _____

YES /NO Often gets lost, even in a familiar city _____

YES /NO Sometimes confuses b and d, especially when tired or sick _____

SOCIAL/BEHAVIORAL HISTORY:

Describe your child's play, interests and activities: _____

Describe any behavioral/emotional problems: _____

Please list the members of your household:

Name

Relationship

Age

Does anyone in your home have a communication problem? If so, please explain: __

Does your child have any relatives (outside the home) who have communication/educational problems? _____

Is there a family history of:

___ **Depression/Anxiety** (please explain) _____

___ **Drug Use** (please explain) _____

___ **Autism/Aspergers** (please explain) _____

___ **High School Drop Out** (please explain) _____

___ **Bipolar/Schizophrenia** (please explain) _____

___ **Dyslexia** (please explain) _____

___ **AD/HD** (please explain) _____

___ Other _____

Did/does your child display any of the following signs? (please explain):

PHYSICAL ACTIVITY: _____

YES /NO EITHER can't sit still, feels restless, has boundless energy, is always fidgeting, has restless feet, etc. –OR- is a couch potato, lethargic, slow, space cadet, is physically there but mentally gone _____

FREQUENT MOOD SWINGS: _____

YES /NO Feels emotions intensely; Higher highs and lower lows _____

YES /NO Low tolerance for frustration; May have rage attacks _____

ATTENTION: _____

YES /NO Trouble deciding what to pay attention to; What's most important _____

YES /NO Trouble getting started on a task; often feels overwhelmed _____

YES /NO Trouble staying focused on repetitive tasks until the task is complete; ___ cant' do homework independently _____

YES /NO Trouble shifting attention to a new task _____

HIGHLY DISTRACTIBLE: _____

YES /NO Distracted by any change in environment, any noise, movement or smell _____

YES /NO Also distracted by their own thoughts; daydreamer _____

YES /NO Can't stay focused for long, except for Nintendo-type games or TV or a new or scary activity; may hyperfocus on a hobby _____

YES /NO Starts many projects but rarely finishes them _____

IMPULSIVE:

YES /NO Can't wait to be called on; blurts out answers in class _____

YES /NO Extremely impatient; difficult to wait for his/her turn _____

YES /NO Often acts before thinking; doesn't seem to learn from mistakes _____

DOESN'T LISTEN WELL:

YES /NO Confused by multi-step oral directions _____

NO TOLERANCE FOR BOREDOM:

YES /NO May start arguments if things are too calm _____

TIME MANAGEMENT:

YES /NO Always rushing; can't slow down _____

YES /NO Makes careless mistakes; hates to doublecheck; _____

YES /NO Doesn't use class time well; Feels rushed by teachers and parents _____

YES /NO Puts most things off until the last minute _____

ODD SLEEP CYCLES:

YES /NO Night owl, hates to go to bed _____

YES /NO Difficult to wake up in the morning _____

YES /NO May be a restless sleeper _____

YES /NO Bedwetting or sleepwalking _____

INCONSISTENT PERFORMANCE:

YES /NO Good days and bad days; some days they can do the schoolwork, other days they can't _____

DISORGANIZED:

YES /NO Messy room, desk, backpack _____

YES /NO Constantly loses or misplaces things _____

OTHER SYMPTOMS:

YES /NO Chatterbox; talks excessively; Interrupts conversations frequently _____

YES /NO Strong sense of justice; bossy _____

YES /NO Lots of allergies _____

YES /NO Terrible penmanship _____

YES /NO Trouble remembering daily routines

YES /NO Relatives with ADD

PHYSICAL ACTIVITY:

YES /NO Either can't sit still, feels restless, has boundless energy, is always fidgeting, has restless feet, etc. –OR- is a couch potato, lethargic, slow, space cadet, is physically there but mentally gone _____

Has your child ever been evaluated or treated for communication/educational impairments in the past? If so, please explain: _____

Does your child have difficulty with:

- Following directions
- Describing events or thoughts
- Responding to questions
- Grammar in speech
- Interacting with peers

Current modes of communication used by child (i.e. pointing, taking parents' hand to object requested, using words, using sentences): _____

How much of your child's speech do you understand?

25% 50% 75% 100%

How much do unfamiliar listeners understand?

25% 50% 75% 100%

EDUCATIONAL HISTORY:

Is your left or right handed? _____

Does your child produce unusual beginning and ending points, slant, or letter size?

Is your child a poor speller? No Yes N/A

Does your child find it challenging to remember phone numbers?

Yes No N/A

Does your child have extremely poor handwriting? Yes No N/A

Does your child tire easily when studying? Yes No N/A

Would you consider your child a poor reader? Yes No N/A

Does your child get embarrassed when asked to read aloud in class/at home?

Yes No N/A

Does your child read well, but has problems with comprehension?

Yes No N/A

Does your child read well, yet chooses to read very little? Yes No N/A

When your child reads silently:

Do they move their lips? ___Yes ___No ___N/A

Do they use their finger to follow along? ___Yes ___No ___N/A

When reading aloud:

Do they often guess at words? ___Yes ___No ___N/A

Do they have problems with “sight” words?

(words that do not sound like they are written) ___Yes ___No ___N/A

Do they have problems with large words? ___Yes ___No ___N/A

Do they have poor enunciation of sounds? ___Yes ___No ___N/A

Do they skip over words? ___Yes ___No ___N/A

Do they skip entire lines? ___Yes ___No ___N/A

Do they often read one word for another? ___Yes ___No ___N/A

Example: Reads bat for bet

Reads came for come (Or Vice Versa for all)

Reads her for hear

Does your child often hear one word for another? ___Yes ___No ___N/A

When you give your child a list of assignments (example: go to your room, pick up your toys, hang up your clothes, make up your bed, and vacuum the floor) will they:

(select all that apply)

___ Get to the room and do one thing

___ Get distracted on the way to the room

___ Have no problem at all

___ Get to the room and forget what to do

___ Get to the room and do two things

Does your child follow instructions better if they: ___ Hear it ___ Read it

Does your child get distracted:

___ Very Easily ___ Easily ___ Occasionally ___ Not at all

Does your child have problems completing a task? ___Yes ___No ___N/A

Is your child overactive or impulsive? ___Yes ___No ___N/A

Does your child have difficulty in copying information from the blackboard or in a book? ___Yes ___No ___N/A

With each glance, is your child able to copy: (select one)

___ a sentence ___ a phrase ___ one word at a time ___ one letter at a time

Does your child have trouble following verbal directions? ___ Yes ___ No ___ N/A

Does your child have trouble following written directions? ___ Yes ___ No ___ N/A

Does your child reverse letters or words? ___ Yes ___ No ___ N/A

Does your child have poor self-esteem? ___ Yes ___ No ___ N/A

Does your child take excessive study time to complete their homework?

___ Yes ___ No ___ N/A

Is homework a frustrating, negative experience? ___ Yes ___ No ___ N/A

Does your child have difficulty understanding or remembering what someone says?

___ Yes ___ No ___ N/A

When you help your child prepare for a test, does your child know the material the night before, but fails the test anyways? ___ Yes ___ No ___ N/A

Please explain the first signs of your child's educational struggles (*i.e.* – *coloring, alphabet, letters, attention, etc.*) _____

***Kindergarten – Name of School** _____

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***First Grade – Name of School** _____

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***Second Grade – Name of School _____**

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***Third Grade – Name of School _____**

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***Fourth Grade – Name of School _____**

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***Fifth Grade – Name of School _____**

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

***Sixth Grade – Name of School** _____

Describe specific struggles, teacher conflicts, testing, IEP, reading programs, etc.

FOR OFFICE USE ONLY: _____

Goals for this evaluation: _____

Questions: _____

Notes (FOR OFFICE USE ONLY): _____

Consent For Release of Information

I, _____ authorize Speech & Learning Connections, LLC to release/obtain

Print parent/guardian name

Information regarding:

Child/client name: _____

Date of birth: _____

City: _____

County: _____

To/from the following institution(s):

Name: _____

Address: _____

Name: _____

Address: _____

Specific Information to be discussed in written and/or verbal communication:

- | | | |
|--|---------|--------|
| 1. OT/PT Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 2. SLP Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 3. Feeding Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 4. Medical Reports/Progress Notes/Treatment Plans | Release | Obtain |
| 5. IFSP/IEP/RCP | Release | Obtain |
| 6. Vision Reports/Progress Notes/Treatment Plans | Release | Obtain |
| 7. Audiological Evaluations/Progress Notes/Treatment Plans | Release | Obtain |
| 8. Financial Status | Release | Obtain |
| 9. Other _____ | Release | Obtain |

The information obtained/released as a result of this form will be used to provide accurate and comprehensive communication among the service provider team.

This consent for disclosure is valid for one (1) year from the date of signature.

I hereby declare that I understand that I have the right to inspect and receive copy of the information disclosed as a result of this form. I understand that I may withdraw consent at any time by written request. I understand that my refusal to consent to disclosure will not result in any other consequence but information will not be disclosed.

Signature of Parent/Guardian

Date

Witness

Date

Send Information to: Basha Ontiveros
Speech & Learning Connections
2412 E. Washington St. Unit 4B
Bloomington, IL 61704
Phone: (309)663-4172

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disability Confidentiality Act, you may not re-disclose any information covered by that Act unless the person who consented to this disclosure specifically consents to such re-disclosure.



Informed Consent for Therapeutic Services

I, _____, authorize Speech & Learning Connections to enroll,
Print name of parent/guardian
_____ in the following services:
Print name of client/child

- Speech-Language Therapy
- Feeding Therapy
- Auditory Processing Therapy
- Hearing Screening (if not already specified by therapist)
- Other (specify) _____

By consenting to these services I declare that I understand, and agree with the following:

1. Orientation regarding services has been explained to me in language that I can understand.
2. My consent to services at Speech & Learning Connections is voluntary and can be withdrawn at any time.
3. Written reports/documentation regarding the client/child will not be released except to those individuals whom have been named in a written, signed release form to accept such correspondence.
4. Clients of Speech & Learning Connections may be observed by others interested in similar services at Speech & Learning Connections, and/or students of occupational therapy, speech-language therapy, and psychology and behavioral studies if deemed appropriate by the treating therapist.
5. The client/child's file will be maintained within Speech & Learning Connections for seven (7) years after discharge.

I have read the above information and fully understand the services in which I hereby consent. I release the agency and their trustees, officers, agents, and employees from any liability to the client any personal injury or property damage suffered by the client as a result of participation in these services. I assume all responsibility and agree to indemnify the agency and hold the agency harmless from and against any and all liability or costs associated with or arising from the client's participation in these services. In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

Parent/Guardian Signature

Date

Witness

Date



General Information and Policies

Speech & Learning Connections offers a complete range of services including speech therapy, language therapy, applied behavior analysis (ABA), reading therapy, dyslexia testing and tutoring, central auditory processing screening, auditory training and more. We maintain information on our website. For this information and more, please visit our website at www.speechandlearningconnections.com

Financial Policies

Our financial policies have been written to clearly explain your responsibility for the services provided to you. If you need further information about any of these policies, please ask to speak with our Office Manager.

Health Insurance: Health care insurance may or may not cover services. We will happily bill insurance for you (**for speech-language therapy only - any classes or tutoring cannot be billed to insurance**) however, payment is ultimately your responsibility. If you have health insurance, please bring your plan identification card with you to your first visit. You are responsible for the difference between what your insurance pays and the total charges for your care, less any discounts if we are contracted providers with your plan. There is no guarantee of coverage. If we are not a participating provider for your plan, all fees are payable at the time which services are rendered and reimbursement will be forwarded to you.

No Insurance: If you do not have health insurance, have not met your deductible or another party has accepted financial responsibility for your care, you must pay for services at the time of your visit. We require payment for the initial consultation fee when you check in that will cover the approximate cost of services, tests and supplies. The **entire** balance is due on the first day of each month prior to all subsequent services rendered. Your child's scheduled session is a reserved spot and must be paid for as such. If payments are not received by the seventh day of each month, a \$25 late fee per month will be assessed until the account is paid in full, unless otherwise agreed upon by this office.

Our time is valuable! Your sessions are contracted and reserved on a monthly basis. We are only able to offer one make-up session per month, provided 24 hours notice is given for any cancellation. There are no make-ups allowed for no-shows! Although we will not bill your insurance for missed appointments, you will be responsible for the full amount for your scheduled session. One week per every six months will be allowed for vacation credit provided we are notified 2 weeks in advance. Please note, tutors and therapists will do their best to reschedule a missed appointment, however there are limited times available for make-up sessions and we can only change your child's time if an open slot is available. In addition, make-up sessions may need to be scheduled with a different therapist or tutor than your child regularly works with. Each semester, you will have an opportunity to request a new schedule that will work for your family.

Collection Agencies: If our monthly statements are ignored, a final statement warning that your account will be placed with a collection agency will be mailed to you. If no payment is received within two weeks of the final notice, the account will be sent to a collection agency, where substantial collection costs of 40% will be added to the account balance. In the event that litigation is warranted, all associated legal fees will be your responsibility as well.

Payment Methods: We accept payment by cash, check, VISA, Mastercard, and Discover. Credit card payments can be taken over the phone. **We require a credit card or debit card to be on file for all clients. This information will be kept secure and will only be used in the event that an account becomes more than 30 days past due.** We are happy to set-up monthly automatic deductions by credit card if appropriate arrangements are made. If you choose to not provide credit card information, all fees are payable at the time services are rendered and insurance benefits will be forfeited.

Returned Checks: If your check is not honored by your bank because of insufficient funds, your account will be assessed a penalty fee not to exceed the amount allowed by law.

Home Visits: We do, in special circumstances, offer therapy in schools and in homes. 15 minute drive time is factored into the allotted time therapy session. For example, a 45 minute session will be billed at 1 hour. If we are billing insurance, you are responsible for the 15 minute drive time charge, as insurance will not cover this.



Privacy Practices

Speech & Learning Connections has been providing specialty services to residents of central Illinois since 2002. We appreciate the trust that you and hundreds of other clients have placed in us, and one of the ways that we will protect that trust is by respecting the privacy of all our clients, even if our formal therapist-patient relationship ends.

We are required by federal and state law to maintain the privacy of your health information. Federal and state laws allow us to use your health information for treatment, payment, and for other limited uses. We cannot use or disclose your health information for any reason not allowed by law unless you give us written permission. The law does not allow us to speak to a member of your family, another relative, or a close friend who may be involved in your care unless you request in writing that we not do so.

You have the right to make an appointment to look at or get copies of your health information from us, with limited exceptions. You must complete a form available from us to receive copies or have access to your information. You also have the right to receive a list of instances in which we or our business associates disclosed your health information, and you have the right to request that we place additional restrictions on our use or disclosure of your health information, but we are not required to agree to communicate with you about your health information by alternative means or to alternative locations.

If you believe your privacy rights have been violated, you may ask to speak with our Privacy Officer, or you may submit a written complaint to the US Department of Health and Human Services.

Speech & Learning Connections diligently maintains physical, electronic, and procedural safeguards that comply with applicable federal standards to guard your private personal information and to assist us in preventing unauthorized access to that information.

Payment Agreement for Speech & Learning Connections

I understand and agree to the payment and attendance policies listed above. I agree that payment is due prior to the time of service unless otherwise arranged by the office manager.

Client/Parent Name(s):

Date

I hereby authorize Speech and Learning Connections to charge my credit card for any balance in the instance that my account becomes 30 days past due.

Credit /Debit Card Type (circle one) Visa Mastercard Discover Exp. Date __ / __ Security Code __ __ __

Credit /Debit Card Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature for authorization _____ Date __ / __ / __