



Child Case History Form (Non-Reader)

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) _____

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: _____

PREGNANCY:

Did you experience any of the following problems during pregnancy?

(Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Accidents/Serious Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spotting/Bleeding | <input type="checkbox"/> Emotional Stress |
| <input type="checkbox"/> RH Neg. | <input type="checkbox"/> Swelling | <input type="checkbox"/> Communicable Disease |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Viral Infection |
| <input type="checkbox"/> Substance Use (smoking/alcohol/drugs) | <input type="checkbox"/> Excessive Weight Gain | |
| <input type="checkbox"/> Other: _____ | | |

Please Describe: _____

Duration of labor: ____ Hours **Child's birth weight:** _____

Anesthesia, if used: ____ None ____ General ____ Spinal ____ Other: _____

Labor: ____ Spontaneous ____ Induced

Length of hard labor: _____

Presentation: ____ Head First ____ Feet First ____ Buttocks ____ Cord around neck

Delivery: ____ Spontaneous ____ Assisted (i.e. forceps) ____ Breech ____ C-Section

What was your child's APGAR score? _____

Comments: _____

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: _____

Other Conditions:

- | | |
|--|---|
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> Cytomegalovirus (CMV) |
| <input type="checkbox"/> Meconium Aspiration | <input type="checkbox"/> Placenta Previa |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) |
| <input type="checkbox"/> Hemorrhage or bleeding | <input type="checkbox"/> Neonatal Seizures |
| <input type="checkbox"/> Asphyxia (Oxygen Deprivation) | <input type="checkbox"/> Rh Incompatibility |
| <input type="checkbox"/> Cleft lip and/or palate | <input type="checkbox"/> Congenital Birth Defects |
| <input type="checkbox"/> Other Physical Abnormalities | <input type="checkbox"/> Eclampsia |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Jaundice: Treatment given: |

Hospitalized in: Regular Nursery Special Care Nursery

Length of Stay in: Regular Nursery Special Care Nursery

Required transfer to another hospital: _____

Reason for extended hospital stay: _____

EARLY INFANCY:

Describe ability to suck, swallow or chew (*where applicable*):

- | | |
|---|---|
| <input type="checkbox"/> Alert | <input type="checkbox"/> Aware of Light |
| <input type="checkbox"/> Aware of Sound | <input type="checkbox"/> Colicky |
| <input type="checkbox"/> Easily Comforted | <input type="checkbox"/> Lethargic |
| <input type="checkbox"/> Difficult to Comfort | |

Feeding History (if applicable):

___ Bottle fed: ___ Formula ___ Milk
___ Bottle fed/Breast fed with supplement: _____
___ NG tube feeding; Reason for placement: _____
___ G-tube feeding; Reason for placement: _____
___ Self feeding; Age began: _____

Began solid foods at age: _____

Current food types taken: _____

Currently, child: ___ Drinks from Cup ___ Finger Foods ___ Uses Utensils

Does child exhibit coughing, choking, drooling, etc., when eating?

Please describe: _____

Describe any feeding and/or nutritional concerns you may have: _____

Has your child's feeding and/or nutrition ever been evaluated? *Please*

describe: _____

Has your child ever experienced difficulty with eating/swallowing or had sensitivities to particular foods? _____

Is your child allergic to any foods or other substances? If so, what? _____

COMMUNICATION DEVELOPMENT:

Please state age of child's development of the following skills:

- | | |
|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Responded differentially to environmental sounds |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Related daily activities (reported past events) |
| <input type="checkbox"/> Saying words | <input type="checkbox"/> Searched for source of voice/sound |
| <input type="checkbox"/> Saying sentences | <input type="checkbox"/> Startled or cried at loud noises |
| <input type="checkbox"/> Feeding self | <input type="checkbox"/> Responded to sounds in environment |
| <input type="checkbox"/> Dressing self | <input type="checkbox"/> Comprehended speech of others |
| <input type="checkbox"/> Potty Trained | <input type="checkbox"/> Requested objects/people by name |
| <input type="checkbox"/> Coo-ing/Babbling | <input type="checkbox"/> Social smiles |
| <input type="checkbox"/> Combined words | <input type="checkbox"/> Used 2 or 3 word phrases |
| <input type="checkbox"/> First words (examples: _____) | |

Does your child display any of these behaviors (check if observed):

- | | |
|--|---|
| <input type="checkbox"/> Rocking | <input type="checkbox"/> Sensitivity to touch |
| <input type="checkbox"/> Difficulty with transitions | <input type="checkbox"/> Jargon |
| <input type="checkbox"/> Sensitivity to loud noises | <input type="checkbox"/> Gags on textured foods |
| <input type="checkbox"/> Excessive drooling | <input type="checkbox"/> Puts non-food items in mouth |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Head banging |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Attention difficulties |

SOCIAL/BEHAVIORAL HISTORY:

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

Does your child prefer to play alone or with others? _____

Does your child exhibit any sleep difficulties? _____

Does your child take regular naps? _____

Describe any behavioral/emotional problems: _____

Describe how speech/language/hearing problems appear to affect your child's interaction with other children: _____

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 problems? _____

Has your child ever been evaluated or treated for communication 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%

Do they have poor enunciation of sounds? Yes No N/A

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 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 trouble following verbal directions? Yes No N/A

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

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

Yes No N/A

Goals for this evaluation: _____

Questions: _____

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

SPEECH & LEARNING C O N N E C T I O N S

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 ___ / ___ / ___