Pediatric and Adult Speech / Swallowing and Feeding Disorders & Pediatric Occupational Therapy
316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452
tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

SPEECH AND LANGUAGE EVALUATION

Identifying Information
Intake Date: ______________________
Patient Name: ____________________________________ Date of Birth: ____________ Age: ______
Parent/Guardians Names: ____
Primary Diagnosis: ____
Pediatrician: ____
Referring Physician: ____
Reason for Referral:
____
____
____

Would you like GSST to share the results of the evaluation with your primary care provider/referring physician: YES NO

Contact Information
Address: ____

City: ____ State: ________________ Zip: ___________
Home Phone: ___________________________ Main Phone: _______________________________
Email Parent: ___________________________ Email Parent: _______________________________

Social History
With whom does the child live (list all): ____
Siblings:(ages) ____
Primary Language Spoken at Home: ____
School/Daycare: ____
Grade: ____ List any Academic Difficulties____

Pertinent Past and Current Medical Information
Prenatal/Birth History
Length of pregnancy (Weeks:)___________________
Were there any complications during pregnancy or delivery? yes / no

If yes, please explain:

____

____

____

Birth weight ________________________________ Apgar Scores ________________________________
Twin: yes / no If yes: ____ identical ____ fraternal
multiple: yes / no If yes: please indicate number ___________

Hospitalization/surgical history
Date(s): ____
Facility: ____
Reason (s) for hospitalization:

____

____

____

Known Precautions/Allergies
Medical allergies: ____ Latex _____ Other: ____
Food allergies: _____ Dairy _____ Gluten _____ Nuts _____ Soy _____
Other: ____
Does your child require an EpiPen for any allergies? ____ Yes _____ No
Food Intolerances: _____ Dairy _____ Gluten _____ Nuts _____ Soy _____
Comments: ____

Current Medications _____ Not Applicable
Medications (include length of use/reason):

____

____

____

Medical History:
Neurologic History/Current Concerns: _____ Not Applicable
HISTORY of neurologic deficits? _____ Yes _____ No
If yes, please describe (e.g., abnormal muscle tone, ataxia, seizures, hyrocephalus):

____

____

____

Has your child ever had any brain imaging studies done? _____ Yes _____ No

CURRENT neurologic status: _____ no concerns _____ concerns ______ regular follow up with neurologist (physician name): ______________________________
If current concerns, please describe:

____

____

____

Has any medical professional ever given your child a specific diagnosis? (mark all that apply)

_____ Developmental Delay/Disorder
_____ Intellectual Disability
_____ Psychiatric Disorder
_____Genetic Disorder: ________________
_____Sleep Disorder
_____ Tic Disorder
_____ Metabolic Disorder
_____ Autism
_____ Failure to Thrive
_____ Alcohol Related Disability
_____ Enuresis/Encopresis
_____ Autoimmune Disorder:________________
_____ Other (specify below):

_____ Asthma
_____ Visual Impairment
_____ Hearing Impairment
_____ Ear Infections
_____ Ear Tubes
_____ Speech-Language Delay
_____ Cardiac History: ____________________
_____ Seizure Disorder
_____ Head Injury
_____ GI History: ________________________
_____ Acid Reflux: (if yes, age of onset):
____

____
____

Did your child experience ANY illnesses or diseases: If yes, what diseases/illnesses? (please list)
____
____

Has your child ever had a hearing evaluation? ___ Yes ____ No
If yes, please explain results: ____
Do you have any concerns with your child's hearing? ____ Yes ____ No
If yes, please explain: ____

Known family history of speech or language problems, special education placements, or learning disability?
Please explain: ____

Related Services:
Has your child ever been previously seen by a

______ Speech-Language Pathologist
______ Occupational Therapist
______ Psychologist
______Neurologist
______ Audiologist
______ Educational Tutor

______ Geneticist
______ Psychiatrist
______ Physical Therapist
______ ENT
______ Developmental Specialist (EI)
______ Neurodevelopmental Pediatrician

If yes, please specify (dates, diagnoses, type of services provided such as evaluation, therapy, etc):
____
____
____

<u>Developmental History</u>

Cognition

Has your child ever been tested for an inability to sit still, pay attention, remember things, or learn like other children his/her age? _____ Yes _____ No
If yes, has a formal diagnosis been given? _____ ADD _____ ADHD _____ ASD _____
Other: ____

If no, do you have any concerns in any of these areas? _____ Yes _____ No
if yes, please explain: ____
(If school age) Learning disabilities: _____ Yes _____ No
If yes, please explain: ____
Is your child regularly being followed by an educational specialist? _____ Yes _____ No
If yes, please provide the name of the specialist/school: ____________________________________

Current Gross Motor Skills
_____ WFL _____ Delayed _____ Impaired
If delayed or impaired, please check all that apply:
_____ Head Control _____ Trunk Control _____ Tone _____ Mobility _____ Other: ______________
Please explain: ____
Is your child regularly being followed by a physical therapist? _____ Yes _____ No
If yes, please provide the name of the therapist: ____________________________________

Current Fine Motor Skills
_____ WFL _____ Delayed _____ Impaired
If delayed or impaired, please explain:
____

Current Sensory Skills
_____ WFL _____ Impaired
If impaired: _____ Hypersensitive _____ Hyposensitive _____ Other: ________________________
Is your child regularly being followed by an occupational therapist? _____ Yes _____ No
If yes, please provide the name of the therapist: ____________________________________

Please share any other concerns you may have regarding your child's development:
____
____
____

Feeding History
Do you have any concerns with your child's feeding development? _____ Yes _____ No
If yes, when did your child's feeding become a concern? ____________________________________
Did your child breast/chest or bottle feed? ____
Did your child have any difficulty with latching (bottle or breast?) _____ Yes _____ No
Do you or your doctor have any concerns regarding the variety of foods that your child will eat?
_____ Yes _____ No
If yes, please explain: ____
Would you consider your child to be a "picky" eater? _____ Yes _____ No
If yes, how many different foods does your child eat? ____________________________________

Current Speech/Communication Skills
Current main mode(s) of communication (select all that apply): _____ Gestures _____ Vocalizations
_____ Speech _____ AAC _____ Other: ___________________
If using speech, please rate speech skills: _____ Within age appropriate limits _____ Delayed
_____ Impaired
At what age did your child perform the following speech tasks:

_____ Coo _____ Babble (reduplicated) _____ Babble (Variegated) _____ Jargon (Adult like intonation)
_____ First words _____ 2 Word combinations _____ 3+ Word combinations _____ Full sentences
_____ Not Applicable
Does your child have a diagnosis of Auditory Processing Disorder? _____ Yes _____ No
Do you have any concerns with your child's comprehension of language? _____ Yes _____ No
If yes, please explain: ____
Estimated size of expressive vocabulary (number of words child produces spontaneously): __________
Estimated size of receptive vocabulary (number of words child understands): ___________________
Does your child use correct word order/grammar in phrases/sentences? ______________________
Is your child regularly being followed by a speech-language pathologist? _____ Yes _____ No
If yes, please provide the name of the SLP therapist/location: _____________________________

How does your child primarily communicate? Please check all that apply
_____ Non-word vocalizations
_____ Gestures and/or pointing
_____ Single Words
_____ 2 Word Combinations
_____Short Phrases
_____Full Sentences
Other: ____________________

What percentage of your child's speech do you understand? ______________________________
What percentage of your child's speech do those outside of your family understand? ______________

Specific Speech and Language Concerns (please check all that apply)
_____ Limited verbal output
_____ Difficulty responding to questions
_____ Difficulty following directions
_____ Speech sound errors
_____ Academic Challenges
_____ Limited vocabulary
_____ Difficulty understanding language
_____ Word finding difficulties
_____ Talks too quickly
_____ Reading difficulty
_____Grammar difficulty
_____ Poor social skills
_____ Memory difficulty
_____ Fluency/Stuttering
_____ Other: __________________

What are your goals for your child's therapy? What do you want your child to achieve by coming to speech and language therapy?

____
____
____
____
____
____

Print Name: _______________ **Signature:** __________________________ **Date**: _______

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Financial Agreement

______ I hereby give Garden State Speech Therapy, LLC authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.

_____ I authorize the release of any medical or other information necessary to process all claims.

_____ I understand that if payment is not issued by the insurance company within 45 days of the initial filing, I am responsible for following up with my insurance carrier and may be responsible for any payments not paid by my insurance carrier to Garden State Speech Therapy, LLC.

______ Invoices are due within 15 days of receipt. A 20% late fee will be added to all late bills.

_____ If patient responsibility payment is not received within 30 days, therapy services might be put on hold. All balances more than 30 days old will be charged to the credit card on file.

_____ I understand that if patient responsibility payment is not made within 60 days, my/my child's appointment time will be forfeited until the balance due is paid in full and therapy services might be terminated. I understand that delinquent accounts may be referred to collections, incur interest collection and attorney's fees for which I will be responsible. Garden State Speech Therapy, LLC does not guarantee the same time slot once the payment has been made.

_____ I understand that a valid credit card on file is required for all scheduled appointments.

_____ GSST will re-submit denied insurance claims twice (2 times). All denied claims thereafter will be billed to the client at billed rate. GSST will make every effort to assist with insurance appeals upon request.

_____ All returned checks will incur a $30 service fee.

_____ I understand that it is my responsibility to inform the office of any insurance changes. Any charges incurred after the termination date of insurance policy are my responsibility

_____ All patient responsibility payments are due at the time of service

Date: ___________________ X____

Print Name: ____

Parent/Guardian for: ____

Garden State Speech Therapy
Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Attendance and Cancelation Policy

Consistent attendance of therapy sessions is paramount for progress. We offer consistent scheduling to all clients, with time slots reserved for each client. Our therapists make a commitment to their clients' progress, we ask that our clients make the same commitment by maintaining their attendance. We will make every effort to schedule make ups for all missed sessions. Make up sessions are offered based upon availability of therapists.

_____ We require 24 hour notice for cancellations. All cancelations of office visits **less than 24 hours in advance** and **no-shows** will incur a **$50 charge**. For traveling appointments, the full rate will be charged. **The $50 cancelation fee will be waived if the appointment is rescheduled and attended within 2 weeks. The $50 no-show fee will not be waived and no-show appointments will not be rescheduled**

_____ **Two (2) canceled and not rescheduled sessions in any 10-week period will result in appointment time loss at the discretion of GSST management. Attendance rate of 80% is expected**

______ **2 consecutive no-shows will result in appointment time loss**

______ I understand that cancelation and no-show fees cannot be billed to my insurance and are my responsibility.

______ Sick children will be sent home. We will do our best to reschedule the appointment.

I have read and understood the attendance and cancelation policy. I hereby accept the attendance and cancelation policy in full.

Date: ________________ X____

Print Name: _______________________________________

Parent/Guardian for: _______________________________________

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Consent and Acknowledgement

Name of client:____

Consent for care and treatment: As (self/parent/legal guardian), I hereby consent to necessary evaluation, procedures, and/or treatments prescribed by the speech therapist as is necessary in their judgment. I understand that I/my child is under the care of a speech language pathologist. I authorize the release of medical information to Garden State Speech Therapy, LLC for continuity of care.

HIPAA Notice of Privacy Practices: Garden State Speech Therapy, LLC will use and disclose personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law.

_________________________________ _____________________________

Signature Date

____

Print Name

____

Relationship to client

Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders

www.gardenstatespeech.com / 201-297-9167

All Information Will Remain Confidential

Patient's name____

Name on card: ____

Billing Address: ____

Credit Card Type: _____Visa ______Mastercard ______Discover

Credit Card Number: ____

Exp. Date:______________ CVV/Security Code:______________

____ I choose to pay my outstanding balance with a credit card. A valid credit card is required to be on file for this option. Please provide the following information.

____ I understand that all balances more than 30 days overdue will be charged to my credit card on file

I hereby authorize Garden State Speech Therapy, LLC to charge the credit card listed above for services rendered. I agree that all sessions booked will be charged at the corresponding rate as stated in the Service Agreement. I agree to keep valid credit card information on file with Garden State Speech Therapy, LLC and to immediately notify Garden State Speech Therapy, LLC if there are any changes to my credit card information. I agree to pay these charges according to my credit card agreement and not to cancel any valid charges, according to this agreement.

____ ______________________

Signature Date