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

Identifying Information

Intake Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Parent/Guardians Names:
_____

Pediatrician: _____

Referring Physician: _____

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: _____

garden state
SPEECH THERAPY

Brothers and Sisters - Name and Age

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

History of Stuttering:

1. Give approximate age at which stuttering was first noticed:

_____

2. Who first noticed or mentioned stuttering?

_____

3. In what situation was the stuttering first noticed:

_____

4. Describe any situations or conditions that might have been associated with the onset of stuttering:

garden state
SPEECH THERAPY

5. Under what circumstances did the stuttering occur after initial onset?

6. What were the first signs of stuttering? (check all that apply)
   a. Repetitions of the whole word (boy-boy-boy) _____
   b. Repetitions of the first letter (b-b-b-boy) _____
   c. Repetitions of the first syllable (ca-ca-cat) _____
   d. Complete blocks on the first letter (b...oy) _____
   e. Prolongations of the vowel? (caaaaat) _____
   f. Visible attempt to speak (i.e mouth movements) but no sound forthcoming?

   g. Other: _____

7. Was the stuttering alway the same or did it occur in several different ways? If it occurred in several different ways, how were they different from one another? Describe.

8. Approximately how long did each block (one word) seem to last?

9. Was the stuttering easy or was there force at the time when the stuttering was first noticed?

10. Were stuttered words primarily at the beginning of the sentence or were they scattered throughout the sentence?

---

11. When stuttering first began, was there any avoidance of speaking (i.e. changing word or stopping mid-stutter, using gestures instead of speech) because of it? Give examples, if any.

---

12. Does or did the child add extra words or sounds to "get started" (i.e. hey mom,hey mom...)

---

13. At the time when stuttering was first noticed, what was your child's reaction?
    a. Awareness that speech was different? _____
    b. Indifference to it? _____
    c. Fear of stuttering again? _____
    d. Surprise? _____
    e. Anger or frustration? _____
    f. Shame? _____
    g. Other? _____

14. What attempts have been made to treat the stuttering problem (either at home or with a professional)?

---

15. Does the child have articulation or pronunciation problems in addition to stuttering? If so, please describe.

---

16. Does the child have hand preference? Right- or left-handed or use both equally well? _____.
17. Does the child have foot preference for kicking a ball? _____
18. Does the child seem to be sensitive or have difficulty adapting to new situations?

---

19. Has the child been diagnosed with ADHD or ADD? _____

Development of Stuttering:

1. Since the onset, has there been any change in stuttering symptoms? Check those that are appropriate.
    a. Increase in number of repetitions per word _____
    b. Change in amount of force used - Increased/Decreased _____
    c. Increase in amount of stuttering _____
    d. Increase in length of block _____
    e. Periods of no stuttering _____
    f. Longer periods of stuttering _____
    g. More precise in speech attempts _____
    h. Lowered voice _____
    i. Slower speech rate _____
    j. Physical struggle (i.e. facial tension, eye blinks) _____
    k. Looking away from the listener _____
    l. Increase in pitch during stutters _____
2. Describe any of the above things the child does when he stutters (i.e. eye blinks).

---

garden state
SPEECH THERAPY

3. Were there any periods (weeks/months) when the stuttering disappeared?

4. Were there any periods (weeks/months) when the stuttering increased?

5. Can you give any explanations for the “worse” periods?

6. Are there any situations that are particularly difficult? If so, describe:

7. List any situations that never cause difficulty:

---

8. Does the child stutter when he or she (check those that apply):
    a. Ask questions _____
    b. Talks to young children _____
    c. Says his or her name _____
    d. Answers direct questions _____
    e. Talks to adults, teachers? _____
    f. Speaks when tired? _____
    g. Talks to family members _____
    h. Uses new words that are unfamiliar _____
    i. Uses the telephone? _____
    j. Reads out loud? _____
    k. Recites memorized material? _____
    l. Talks to strangers? _____
    m. Speaks when excited? _____
    n. Talks to friends? _____
9. Do you know anyone who stutters? Are they relatives? Friends? Acquaintances?

---

10. Do you feel that stuttering interferes with your child's daily life, social relationships or success in school?

---

garden state
SPEECH THERAPY

Medical, Developmental and Family History

1. Describe mother's health during pregnancy and birth history (i.e. complications):

2. Describe any development problem during infancy or early childhood (i.e. late to walk or talk, feeding problems,food allergies):

garden state
SPEECH THERAPY

3. Do you think the child's speech and language development was unusually rapid or delayed? If so, please describe

4. List all significant illnesses, injuries, severe fevers, and operations (include date, illness,complications,treatment, physician)

5. List any medications your child is on:

6. List all present disabilities:

garden state
SPEECH THERAPY

7. Any chronic illnesses, allergies, or physical conditions

8. Vision Normal? _____
9. Hearing normal? _____
10. Child's eye color? _____
11. Hair color? _____.
12. Do you members of the family have speech, language, reading problems , or learning disabilities? If so, please describe:

13. Are any family members left handed or use both right and left hands equally well?

garden state
SPEECH THERAPY

14. Does the child or other family members show artistic talent or interest?

15. Do any family members talk very rapidly? If so, who?

School and Social History:

1. Favorite subjects or activities in school:

2. Difficult subjects:

garden state
SPEECH THERAPY

3. Hobbies:

4. Sports:

5. Leisure time activities

6. Favorite toys:

7. What specific questions do you have about your child that you would like us to try to answer?

garden state
SPEECH THERAPY

8. In addition, what goals would you like to see accomplished as a result of this evaluation

_____

_____

_____

Signature:

Date:

garden state SPEECH THERAPY

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

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

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