Garden State Speech Therapy

Pediatric and Adult Speech
Swallowing and Feeding Disorders

661 East Palisades Ave, Suite A6. Englewood Cliffs, NJ 07632
265 Ackerman Ave, Suite 203. Ridgewood, NJ 07450
223 Old Hook Rd, Suite 2. Westwood, NJ 07675
www.gardenstatespeech.com / 201-297-9167

PEDIATRIC BACKGROUND HISTORY QUESTIONNAIRE

Intake Date: _____
Full name of child:_____DOB:_____Age: Male/Female:_____
Parents/Guardians Names:_____
Address:_____
City:_____ County:_____
State:_____ Zip: :_____

Home Phone:_____Cell Phone:_____Work Phone:_____
Main Phone: _____
Email Mother:_____Email Father:_____Main Email:_____
With whom does the child live (list all family members):_____
Language(s) spoken in the home (please list):_____
Person providing intake:_____
Who referred child:_____Phone:_____
Primary care provider:_____Phone:_____
Present medical diagnoses including psychiatric diagnoses (if applicable):_____
Present educational classification (if applicable): _____
Present speech-language diagnoses (if applicable):_____

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PREGNANCY AND BIRTH HISTORY:

Maternal age at the time of pregnancy: _____

Paternal age at the time of pregnancy: _____

When you were pregnant with this child, were you under the care of a physician? Yes_ No____

Did you experience any difficulties or notable events (illness, accidents, trauma, etc) during pregnancy?

If yes, please describe:_____

Was there any maternal alcohol use during pregnancy? No_ Yes___

If yes, describe alcohol intake per day:_____

Was there any paternal alcohol use during pregnancy? No_ Yes___

If yes, describe alcohol intake per day:_____

Was there any maternal drug use during pregnancy? No_ Yes___

If yes, describe drug intake per day: _____

Was there any paternal drug use during pregnancy? No_ Yes___

If yes, describe drug intake per day: _____

Was your child born full term? _____

Length of pregnancy:_____weeks

Child's birth weight _____ Was there any birth or medical complications? If yes, please describe:

Known family history of speech or language problems? No_____ Yes___

Please explain: _____

Known family history of special education placements or learning disabilities? No___ Yes___

Please explain: _____

Known family history of mental health difficulties/psychiatric diagnoses? No_ Yes___

Please explain: _____

Known family history of substance abuse (e.g., illicit drugs, alcohol, prescription medication)? No____Yes___

Please explain: _____

Known family history of abuse or neglect (e.g., physical, sexual, emotional, etc)? No_ Yes___

Please explain: _____

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MEDICAL HISTORY:

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

_____Psychiatric Disorder	_____Autism Spectrum Disorder	_____Hearing Problems
_____Cerebral Palsy	_____Tic Disorder	_____Speech-Language Delay
_____Developmental Delay	_____Failure to Thrive	_____Seizure Disorder
_____Intellectual Disability	_____Alcohol Related Disability	_____Head Injury
_____Sleep Disorder	_____Enuresis/Encopresis	_____Cardiac Problems
_____Metabolic Problems	_____Immune Disorder	_____Vision Problems
_____Genetic Disorder	_____Asthma	_____Other (specify below):

Did your child experience ANY illnesses or diseases: No____ Yes___

If yes, what diseases/illnesses? (please list) _____

_____

_____

Does your child have any allergies? No____ Yes___

If yes, please describe:_____

Does you child have any difficulties with feeding/eating? No____ Yes___

If yes, please describe:_____

Did your child take any medications in the past? No____ Yes___

If, yes, please list the name of medications, the dates they were taken, and the reason (s) for taking them _____

_____

_____

Is your child currently on any medications? No_____ Yes___

If, yes, please list the name of medications, their dosage, and the reason (s) for taking them_____

_____

_____

Former medical diagnoses?_____

_____

RELATED SERVICES:

Has your child ever been previously seen by a

_____Speech-Language Pathologist	_____Audiologist	_____Physical Therapist
_____Occupational Therapist	_____Educational Tutor	_____ENT
_____Psychologist	_____Geneticist	_____Developmental Specialist (EI)
_____Neurologist	_____Psychiatrist	_____Neurodevelopmental Pediatrician

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

_____

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Please attach all relevant reports to this form

HEARING:

Do you think/know your child has problems hearing? No_ Yes___
If yes, please explain;_____
Date and results of last hearing test: _____
Number and frequency of ear infections:_____
How have the ear infections been treated? (describe)_____
Has your child had pressure equalizing tube placed? No_ Yes___
If yes, when were they placed and by what doctor?_____

AUDITORY PROCESSING (for children >6 years of age):

Does your child have a diagnosis (from a audiologist) of an Auditory Processing Disorder? No_ Yes___
If yes, when was it diagnosed and by whom? _____
Please attach testing results to this form

If no, do you have any concerns regarding your child's processing of language? (e.g., listening comprehension, understanding verbal directions and instructions) No_____ Yes___
If yes, please explain;_____
Does your child ask you to frequently repeat information/questions? No____ Yes___
Does your child require extended processing time to answer questions? No____ Yes___
Do you have any other concerns regarding your child's ability to process information? No_____ Yes___
If yes, please explain:

DEVELOPMENT:

Motor Milestones (age achieved in months)

Sat alone:_____ Crawled:_____ Walked:_____
Learn simple games (e.g. peek-a-boo) _____ Potty trained: ____

Oral Motor

Age of transition from nursing:_____ Age of transition from bottle to open cup:____
Age of eating solid food:_____ Feeding self from spoon: ____
Did or does your child (check all that apply):
_____Use a pacifier No____ Yes___ Age when stopped: _
_____Suck thumb and/or fingers No____ Yes___ Age when stopped: _

Did your child drool other than when he/she is/was cutting teeth? No____ Yes___

If yes, please explain:

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Speech and Language:

Did your child vocalize (cry, coo, babble) normally as an infant? Yes___ No____
If no, please describe:

Age of reduplicated babbling (ba-ba-ba): _____
Age of variegated babbling (ba-da-ga): _____
Age of jargon words (nonsense sounding sentence-like utterances with adult-like intonation): _____
Age of first meaningful words other than "mama/dada"?_____
Age of two-word combinations?____Examples:_____
Age of 3+ word sentences:_____Examples:_____
Estimate the size of receptive vocabulary (number of words child understands)_____
Estimate the size of expressive vocabulary (number of words child spontaneously uses)_____
Does the child uses correct word order (grammar) used in sentences/phrases? Yes___No____N/A_____
If no or does not apply, please describe:

How well does your child understand what is being said to him/her? (ability to follow directions and understand meaning of words)_____

What is the current communication style(s) used by your child? (check the highest level unless child has difficulty for his/her age then check all that apply)

_____Non-word vocalizations _____Gestures and/or pointing _____Words and gestures
_____Single words _____Two word combinations _____Short phrases
_____Full Sentences _____Other _____

What percent of your child's speech do you (parents) easily understand?_____
What percent of your child's speech do those outside of the family easily understand?_____
Do you feel your child is delayed in any areas such as social, motor, learning, feeding? Yes_ No____
If yes, please explain:

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Specific Speech Language Related Concerns
Please check all that apply:

____Limited verbal output	____Limited vocabulary	____Poor grammar
____Difficulty responding to questions	____Difficulty understanding language	____Poor social skills
____Difficulty following directions	____Word finding difficulties	____Memory difficulty
____Speech sound errors	____Talks too quickly	____Stutters
____Academic challenges	____Poor reader	____Other (explain)

Occupational Therapy:
Does your child respond appropriately to sensory experiences (touch, taste, movement)? Yes _ No____
Do you have concerns about your child's overall coordination? Yes___ No____
Does your child participate in self-care activities (tooth brushing, mealtime, dressing etc.) as you would expect?
Yes___ No____
If your child is nearing or is school-aged, do you have concerns about handwriting, coloring, and/or use of scissors?
Yes___ No___

EDUCATION:
Is your child enrolled in any type of childcare facility, preschool program, or play group? No____ Yes___
Is your child enrolled in public or private school? No____ Yes___

Name of School/Facility:_____Date enrolled:_____
Hours enrolled per week:_____Current grade level:_____
Performance level: Average_____ Below Average_____ Above Average_____
Teacher's Impressions:_____
Do you agree/disagree? _____
If disagree, Why _____
Describe any special assistance or help provided in the educational setting:

BEHAVIOR and PERSONALITY:
Please check characteristics which best describe your child:

___Shy	___Social/Outgoing	___Overactive	___Impulsive
___Affectionate	___High strung	___Tantrum prone	___Inattentive
___Excessively talkative	___Quiet	____Perseverates (get stuck) on thoughts/ideas	
___Demanding	___Stubborn	___Indiscriminately friendly	
___Attention seeking	____Difficulty separating from parent		___Excessively moody

___Responds positively when praised ___Respond poorly when criticized

____Artistic ____Cooperative ____Insightful

____Likes to please ___Motivated ____Intelligent ____Good with his hands

____Gets along great with others (good social skills)

Other (specify):

_____

_____

Does your child display any behaviors that concern you? No____ Yes___

If yes, please describe:

Preschool/Toddler: Please list your child's preferred toys _____

_____

School Age: Please list your child's preferred activities _____

_____

What motivates your child? (Please list all that applies) _____

_____

_____

List any additional information that you feel is important for the speech language pathologist to know (e.g., child's most pressing difficulties, etc) here: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Print Name:_____ Signature:_____ Date:_____

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Service Agreement

Financial responsibility

_____ 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 your insurance carrier to Garden State Speech Therapy, LLC.

_____ I understand that if payment is not made within 60 days, my child's appointments will be placed on "Hold" until the balance due is paid in full.

_____ 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.

_____ Bills are due within 15 days of receipt. A 20% late fee will be added to all late bills. If payment is not received within 30 days, the delinquent account may be referred to collections ad your child may be discharged from therapy. I understand that delinquent accounts may incur interest collection and attorney's fees for which I will be responsible.

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

_____ I understand that it is my responsibility to inform the office of any insurance changes.

_____ All co-pays/payments are due at the time of service

Cancelation Policy

_____ We require 24 hour notice (with the exception of sudden illness/weather) for cancellations. All short notice cancelations of office visits (less than 2 hours) and no-shows will incur a $35 charge. For traveling appointments, the full rate will be charged.

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

_____ 3 consecutive no-shows will result in appointment time loss.

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

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SPEECH THERAPY

Consistent attendance of therapy sessions is paramount for progress. We will make every effort to schedule make ups for all missed sessions. Make up sessions are offered based upon availability of therapists. Four (4) consecutive canceled and not rescheduled sessions will result in appointment time loss.

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

Date: _____ X_____

Print Name: _____

Parent/Guardian for: _____

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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

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____ 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.

All Information Will Remain Confidential

Name on card: _____

Billing Address: _____

Credit Card Type: _____Visa _____Mastercard _____Discover

Credit Card Number: _____

Exp. Date:_____ CVV/Security Code:_____

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, *unless the session is cancelled 2 hours in advance*. 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