

**PEDIATRIC SPEECH, LANGUAGE AND HEARING HISTORY****IDENTIFICATION:**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

**FAMILY HISTORY:**

Father \_\_\_\_\_

Mother \_\_\_\_\_

Marital Status of Parents \_\_\_\_\_

Brothers and Sisters:

NameAge

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other persons living in the home \_\_\_\_\_

Please describe, in your own words, the child's speech language, voice or reading problem.

\_\_\_\_\_  
\_\_\_\_\_

What do you believe may have caused the problem? \_\_\_\_\_

\_\_\_\_\_

Who first noticed the problem and when? \_\_\_\_\_

\_\_\_\_\_

**PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY:**

Were there any complications and illnesses during this pregnancy? \_\_\_\_\_

\_\_\_\_\_

Was delivery normal? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

\_\_\_\_\_

To the best of your knowledge, at what ages did the following first occur?

Held head up \_\_\_\_\_ Walked alone \_\_\_\_\_ Put words together \_\_\_\_\_  
 Sat up \_\_\_\_\_ Began to babble \_\_\_\_\_ Dressed Self \_\_\_\_\_  
 Crawled \_\_\_\_\_ Imitated sounds \_\_\_\_\_ Tied shoes \_\_\_\_\_  
 Stood alone \_\_\_\_\_ Said first word \_\_\_\_\_

Which hand does the child prefer to use?            Right            Left

**MEDICAL HISTORY:**

Please circle those diseases child has had and indicate age and duration:

	<u>Age</u>	<u>Duration</u>		<u>Age</u>	<u>Duration</u>
1. Measles	_____	_____	6. Pneumonia	_____	_____
2. Whooping Cough	_____	_____	7. Ear Aches	_____	_____
3. Scarlet Fever	_____	_____	8. Convulsions	_____	_____
4. Chicken Pox	_____	_____	9. Allergies	_____	_____
5. Mumps	_____	_____	10. Other _____	_____	_____

List and describe any accidents, injuries, operations or hospitalizations:

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List any current medical treatments or medications: \_\_\_\_\_

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Does your child have any of the following?

Visual defect _____	Emotional problems _____
Hearing defect _____	Behavior problems _____
Hearing aid _____	Defect of tongue, jaw, _____
Cleft Palate _____	teeth or lips _____
Other physical defects _____	

Child's Physician \_\_\_\_\_ Phone# \_\_\_\_\_  
 Address \_\_\_\_\_

Other Physicians:

<u>Name</u>	<u>Specialty</u>	<u>Address</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

Other Clinics or Professionals who have examined the child (such as psychologists, speech pathologists, etc.):

<u>Name</u>	<u>Specialty</u>	<u>Address</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

**SOCIAL:**

What kinds of play does your child enjoy most? \_\_\_\_\_

\_\_\_\_\_

How does your child get along with friends? \_\_\_\_\_

\_\_\_\_\_

How does your child get along with family members? \_\_\_\_\_

\_\_\_\_\_

Does your child prefer to play alone? \_\_\_\_\_ Does your child play alone as well as play with other children? \_\_\_\_\_

How would you describe your child's disposition? What are the main personality traits? \_\_\_\_\_

\_\_\_\_\_

What kind of activities are engaged in by the entire family? \_\_\_\_\_

\_\_\_\_\_

Is your child in a school or pre-school setting? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

\_\_\_\_\_

How does your child get along there? \_\_\_\_\_

How does your child react to discipline? \_\_\_\_\_

**SPEECH AND LANGUAGE:**

How does your child usually communicate with you (speech-gestures, etc.)?

\_\_\_\_\_

Is the child's speech generally understood by: Family \_\_\_\_\_  
Other children \_\_\_\_\_ Other Adults \_\_\_\_\_

Does your child usually understand what you say to him/her? \_\_\_\_\_

If not, how do you communicate with him/her? \_\_\_\_\_

\_\_\_\_\_

Have you tried to help your child's speech? \_\_\_\_\_

\_\_\_\_\_

If your child has had speech therapy, indicate when, by whom, for how long and whether, in your opinion it was beneficial.

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**GENERAL:**

What language(s) are used in the home? \_\_\_\_\_

Do any other immediate family members have a history of speech or language problems? If so, describe: \_\_\_\_\_

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Have any other immediate family members ever had unusual illnesses, emotional problems or learning disabilities? If so describe: \_\_\_\_\_

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Has your child's hearing been tested? Y N If yes, what was the outcome? \_\_\_\_\_

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Please give any additional information you believe may bear on your child's problem:

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Date \_\_\_\_\_

Report filled out by \_\_\_\_\_

Relationship to child \_\_\_\_\_

**Case History for Children With Feeding Problems**

**Complete this form if your child is 6+ months and beginning to eat / already eating solids**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Primary caregiver(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (other) \_\_\_\_\_

Primary care physician \_\_\_\_\_

Other physicians who see the child \_\_\_\_\_

Why is your child being seen for a feeding evaluation?  
\_\_\_\_\_  
\_\_\_\_\_

When did these problems begin? \_\_\_\_\_

Please list anyone else who has evaluated your child for this feeding problem.  
\_\_\_\_\_  
\_\_\_\_\_

**Prenatal and Perinatal Medical History**

Weight of your child at birth \_\_\_\_\_ Was your child full term? \_\_\_\_\_

If premature, how many weeks gestation? \_\_\_\_\_

How long was your child hospitalized after birth? \_\_\_\_\_

Describe any problems during pregnancy.  
\_\_\_\_\_  
\_\_\_\_\_

Describe any problems during or immediately after birth.  
\_\_\_\_\_  
\_\_\_\_\_

**Postnatal Medical History**

Does your child have any medical diagnoses? If yes, please list.  
\_\_\_\_\_  
\_\_\_\_\_

Describe any family history of similar problems. \_\_\_\_\_  
\_\_\_\_\_

If your child has ever been hospitalized, list dates and reasons.  
\_\_\_\_\_  
\_\_\_\_\_

Describe any special medical tests.  
\_\_\_\_\_  
\_\_\_\_\_

Describe any dental problems

\_\_\_\_\_

If your child has had any surgeries, list dates and reasons.

\_\_\_\_\_

Describe any respiratory problems (e.g., pneumonia, bronchitis, asthma, noisy breathing).

\_\_\_\_\_

Describe any gastrointestinal problems (e.g., vomiting, diarrhea, constipation, gas).

\_\_\_\_\_

List any medications your child takes and the reason for the medicine.

\_\_\_\_\_

Describe any allergies.

\_\_\_\_\_

### **Sleep Patterns**

When does your child go to bed at night? \_\_\_\_\_

How many hours does he or she sleep? \_\_\_\_\_

Does your child nap during the day? \_\_\_\_\_ If yes, when and how long does your child sleep?

\_\_\_\_\_

Does your child sleep through the night? \_\_\_\_\_ Does your child snore? \_\_\_\_\_

Is your child a mouth-breather when asleep? \_\_\_\_\_

### **Food and Nutrition**

#### **Feeding Milestones**

Was your child breast-fed? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

Does your child still breast-feed? \_\_\_\_\_

Did your child have any trouble with breast-feeding (e.g., poor suck, slow to feed, poor latch)?

\_\_\_\_\_

When was your child's first bottle? \_\_\_\_\_ Did your child have any trouble with the bottle? \_\_\_\_\_

If yes, please describe.

\_\_\_\_\_

At what age did your child try cereal? \_\_\_\_\_

Describe any problems encountered with spoon feeding cereal and other solids? \_\_\_\_\_

When was your child weaned from the breast or bottle to cup drinking? \_\_\_\_\_

Describe any problems with moving to cup drinking

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**At what age did your child begin to eat foods that require biting/chewing?** \_\_\_\_\_

**Describe any problems with biting/chewing** \_\_\_\_\_

**Current Information**

What is your child's current weight? \_\_\_\_\_ height? \_\_\_\_\_

Where does your child fall on the growth charts? \_\_\_\_\_ percentile weight \_\_\_\_\_ percentile height

How would you describe your child's appetite? Good fair poor varies

Please explain.

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Which of the following does your child drink? " cow's milk " soy milk " breast milk " formula- type of formula: \_\_\_\_\_

If your child is nursing, does mother have adequate production of milk? \_\_\_\_\_

How much of the following does your child eat and drink in a typical 24-hour period?

food \_\_\_\_\_ liquid \_\_\_\_\_ supplements \_\_\_\_\_

How many times a day does your child eat? \_\_\_\_\_

How long is it between meals? \_\_\_\_\_

How long does each meal take? \_\_\_\_\_

Does your child use any special equipment to eat? " bottle " nipple " cup " spoon

If yes, please describe. \_\_\_\_\_

What is your child's position when eating/being fed? held by caregiver " in high chair " in seating device (describe position \_\_\_\_\_)

Does your child eat more/less/same amount in the following situations?

with other relatives \_\_\_\_\_ with other adults (e.g., babysitter) \_\_\_\_\_

at school/daycare \_\_\_\_\_ with others \_\_\_\_\_

Does your child receive any supplemental feeding? \_\_\_\_\_

If yes, please circle: NG PEG PEJ oral supplements

Who usually feeds your child or do they self-feed?

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Which, if any, of these behaviors does your child exhibit during a meal? " crying " spitting out food " holding food in mouth " gagging " vomiting " refusing to eat " turning head away " clamping mouth shut

When this happens, what do you do?

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What does a typical meal look like : (include what your child eats/drinks and how much of each, do you have to thicken the liquids?)

Breakfast

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Lunch

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Dinner

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Snack

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What temperature foods and liquids does your child prefer: Room temperature Warm Cold

What foods are easy for your child to eat: \_\_\_\_\_

What foods are difficult: \_\_\_\_\_

Where does your child typically eat at home?

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Person Completing Form

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Date



**Case History for Infants/Children With Feeding Problems**

**Complete this form if your child is 0-12 months and not yet eating solids**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Primary caregiver(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (other) \_\_\_\_\_

Primary care physician \_\_\_\_\_

Other physicians who see the child \_\_\_\_\_

Why is your child being seen for a feeding evaluation?

\_\_\_\_\_  
\_\_\_\_\_

When did these problems begin? \_\_\_\_\_

Please list anyone else who has evaluated your child for this feeding problem.

\_\_\_\_\_  
\_\_\_\_\_

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How long was your child hospitalized after birth? \_\_\_\_\_

Describe any problems during pregnancy.

\_\_\_\_\_  
\_\_\_\_\_

Describe any problems during or immediately after birth.

\_\_\_\_\_  
\_\_\_\_\_

**Postnatal Medical History**

Does your child have any medical diagnoses? If yes, please list.

\_\_\_\_\_  
\_\_\_\_\_

Describe any family history of similar problems.

\_\_\_\_\_  
\_\_\_\_\_

If your child has ever been hospitalized, list dates and reasons.

\_\_\_\_\_  
\_\_\_\_\_

Describe any special medical tests.

\_\_\_\_\_  
\_\_\_\_\_

If your child has had any surgeries, list dates and reasons.

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Describe any respiratory problems (e.g., pneumonia, bronchitis, asthma, noisy breathing).

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Describe any gastrointestinal problems (e.g., vomiting, diarrhea, constipation, gas).

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List any medications your child takes and the reason for the medicine.

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Describe any allergies.

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### **Sleep Patterns**

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When was your child's first bottle? \_\_\_\_\_ Did your child have any trouble with the bottle? \_\_\_\_\_  
If yes, please describe.

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#### **Current Information**

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How would you describe your child's appetite? Good fair poor varies  
Please explain.

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If yes, please describe. \_\_\_\_\_

What is your child's position when eating/being fed? held by caregiver " in high chair " in seating device  
(describe position \_\_\_\_\_)

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Does your child receive any supplemental feeding? \_\_\_\_\_

If yes, please circle: NG PEG PEJ oral supplements

Who usually feeds your child?  
\_\_\_\_\_

Which, if any, of these behaviors does your child exhibit during a meal? " crying " spitting out food  
" holding food in mouth " gagging " vomiting " refusing to eat " turning head away " clamping mouth  
shut

When this happens, what do you do? \_\_\_\_\_

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Person Completing Form

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Date



## **Cancellation/No Show/Co-Pay Policies**

Thank you for choosing John Muir Health for your therapy services. Due to the volume of new patients and limited appointments, we require that you notify our office **24 hours in advance** if you are unable to keep your appointment. We do understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a “No Show.” **After two such occurrences, any additional scheduled appointments will automatically be cancelled.** Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than ten minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system’s billing department.

We want to meet the goals of all of our patients and appreciate your assistance. Thank you for your help! Please let us know if there is something more we can do for you.

**To cancel or reschedule appointments, please call (925) 947-5300.**

Sid Hsu, Director  
Rehabilitation Services  
John Muir Health

I acknowledge that I have read and understand these policies.

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Patient Signature

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Date



**SCHEDULING COMMUNICATION PREFERENCE**

*Please Print*

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding scheduling issues.

- No, it is not ok to leave messages or voicemails.
- Yes, it is ok to leave messages or voicemails.

**Please write all of YOUR contact numbers where we may leave a message:**

Home Phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_  
 (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Persons authorized to receive messages/information at above numbers**

Name	Relationship	Name	Relationship
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Only the above people will be able to confirm or change your appointment.

Please note: ANY PERSON (including family members) requesting **ANY** information, including appointment confirmations and changes, **MUST** provide us with 3 points of information about you including: 1. Name, 2. Date of Birth, 3. Zip Code.

Thank you for assisting us.

I authorize John Muir Therapy Center to leave protected health information inquiries that may include the following: Name of patient; Name and phone number of our clinic; Name of treating Therapist(s) or Doctor; Name of referring Doctor; Appointment times and dates; and Scheduling information/requests.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship, if not patient: \_\_\_\_\_

**1. Preferred language for discussing healthcare with your provider:** \_\_\_\_\_

**2. Do you consider yourself of Hispanic or Latino Ethnicity?** **Yes** **No**

**3. Which category best describes your race? Circle One**

- Asian      Black/African-American/African      Pacific Islander or Native Hawaiian  
 Caucasian      Native American/American Indian/Eskimo      Multi-racial/Bi-racial      Other

## CONDITIONS OF REGISTRATION

**Consent to Medical and Surgical Procedures:** The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or Facility services rendered the patient under the general and special instructions of the patient's physician or surgeon.

**Personal Valuables:** The Facility shall not be liable for loss or damage to personal property.

**Trainees:** The Facility conducts training programs for health care professionals. These persons may be observing or participating in the Facility's treatment program. They will be under the direct supervision of licensed professionals. The undersigned has a right to refuse to have trainees participate, at any time, in his/her care.

**Consent to Photography:** The undersigned consents to photography (still images, videotaping, filming, etc.) for purposes related to diagnosis and treatment or for use in training or education programs.

**Release of Information upon Public Inquiry:** Requests for patient information must contain the patient's name. The Facility may then, unless otherwise requested by the patient, legal representative, or provider of health care, release at its discretion the patient's condition described in general terms (that do not communicate specific medical information) and the patient's location within the hospital. The Facility will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the Facility is permitted or required by law to release information. No information will be released to the public with regards to psychiatric and/or chemical dependency treatment.

**Release of Information for Payment:** To the extent necessary to obtain payment, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including, but not limited to, insurance companies, Health Care Service Plans, workers' compensation carriers, social security administration and peer review organizations. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

**Financial Agreement:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

**Assignment of Insurance Benefits:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

**Health Care Service Plans:** It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

***The undersigned acknowledges he/she has read and understands the Conditions of Registration and has received a copy thereof. Furthermore, the undersigned is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.***

\_\_\_\_\_  
PRINT NAME: PATIENT, LEGAL REPRESENTATIVE, AGENT

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
DATE/TIME

\_\_\_\_\_  
RELATIONSHIP IF NOT PATIENT

\_\_\_\_\_  
WITNESS

Unable to sign

**Acknowledgement of the Notice of Privacy Practice**  
***The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices.***

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

\_\_\_\_\_  
SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT



Dear Parent/Guardian:

Thank you for choosing John Muir Health for your therapy services.

We strive to provide the best care to each patient and appreciate your assistance.

We ask that you remain on the premises to allow for discussion of your child's care/treatment or should there be any type of emergency.

We understand siblings may need to accompany you to your child's appointment(s). In such circumstances please monitor the safety of all siblings while on the premises and for safety reasons please do not allow them to use any therapeutic equipment or toys.

Thank you,

Sid Hsu, Director  
John Muir Health  
Rehabilitation Services

I acknowledge and understand the need to be present during my child's appointment. John Muir Health will not be held liable for my child's welfare in the absence of a parent/guardian and may contact emergency services as necessary to safeguard my child. I accept responsibility for monitoring the behavior and safety of siblings that may attend therapy sessions. John Muir Health will not be held liable for any injury a sibling may incur due to lack of parental supervision.

Parent/Guardian Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

## Food Preferences and Refusals

**Child's Name:**

**Completed By:**

**Date:**

Please list foods and drinks your child likes and dislikes. If you prepare any of these foods in a certain way in order for your child to eat it, please describe. (Ex. If you have to cut sandwiches in a certain shape, or apples only peeled and cut into chunks, macaroni & cheese if only certain brand)

Drinks	
Likes	Dislikes

Breakfast Foods	
Likes	Dislikes

Breads	
Likes	Dislikes

Vegetables	
Likes	Dislikes

Fruits	
Likes	Dislikes

Meats	
Likes	Dislikes

Snacks	
Likes	Dislikes