Case History

Date: __________________

Name of person completing form_________________Relationship to Child_______________

Child's Name:________________________Gender________Birthdate___________________

Address:_________________________City______________State____Zip_________________

Home #:___________________Work#___________________Cell#______________________

Your Email address____

Insurance Carrier_________________________ ** Please provide a copy of Ins. Card front/back

Policy #__________________________________

Physician Name___________________________ Physician Phone______________________

Please circle best way to contact you: Phone Email

Family History

Father's Name:____Age:_______

Education(last grade attended):____

Present Occupation:____

History of Delays:____

Mother's Name:____Age:________

Education (last grade attended):____

Present Occupation:____

History of Delays:____

Siblings:

Name	Age	Any Delays
______________________	____	_______________
______________________	____	_______________
______________________	____	_______________
______________________	____	_______________

Delivery:

Duration of labor:_______________________Term:__________________________________

Normal_____________Instrument____________Breech___________Caesarian_________

Birthweight________________

Unusual conditions at or immediately after birth____________________________________

Developmental Milestones: (Please check which one applies)

Achieved within normal limits________

Delayed______________________________

List specific delay (s)____

____

____

If adopted at what age was your child adopted? ______________________________________
Please include any information pertinent to the adoption.________________________________
____
____

Medical History

Diseases:	Age	Severity	Diseases:	Age	Severity
Chicken Pox	___	_______	Encephalitis	____	_______
Measles	___	_______	Mumps	____	_______
Scarlet Fever	___	_______	Meningitis	____	_______
Rheumatic Fever	___	_______	Whooping		
Pneumonia	___	_______	Cough	____	_______
Influenza	___	_______	High Fevers	____	_______
Asthma	___	_______	Earaches	____	_______
Hay Fever	___	_______	Other	____	_______

Surgery:____
____
Injuries:____

Hearing:
Has your child experienced frequent ear infections? How frequent:___________________________
Otological care of surgery:_____________________ Date of last hearing screen:________________
Hearing concerns/issues:____

Vision Impairments or Concerns:
If yes please explain:____

Does your child have any medical or school related diagnosis? If yes, please list and include who made the diagnosis and when was it made.____________________________________
____
____

Does your child currently take any medications? If yes, please list the medication and for what condition it is taken. Please list any behaviors your child exhibits that you believe might be attributed to taking the medication. ____
____
____

If your child is nonverbal, describe how your child communicates with you, please give examples.
____
____
____

Speech History

1. Age first word spoken:___________Age 2-3 word combinations spoken:__________

   Age first sentences spoken:____

2. Rate of speech development: Fast:__________Average:________Slow:___________

3. Describe his/her speech at the present time:__________________________________

   ____

4. Is his/her speech easily understood by the listener?____________________________

5. When did you first become concerned about his/her speech?____________________

   ____

6. Intelligibility of child's speech: (X any that apply)

   easily understood__________understood if listener knows topic_________________

   words understood now and then_______________completely unintelligible________

7. Primary language spoken at home:______________________________

   If other than English what is language?__________________________
   Does child understand and speak English language?_________________________________

   List any previous speech evaluations:_______________________________________

   Agency:______________________________Date:___________________________

   Comments:____

   Additional comments/concerns:____

Advantage Therapy, LLC
8402 Six Forks Rd Ste #101 Raleigh, NC 27615 • Phone 919.847.6773 • Fax 919.847.6827 Email
info@advantagespeechtherapy.com

Daily Routines: Please describe your child's level of independence and behavior for each of the items below.

Meal Time: Please list what your child likes to eat, his/her appetite and behavior during mealtimes.
____
____
Eats with fingers____ Uses a spoon____ Fork____ Spreads with a knife___________

Dressing: How does your child typically get dressed? Include type of clothes they wear, how long it takes to get dressed and behavior during that time.____
____.
Undresses self____ Dresses self_____ Manages snaps, buttons, zippers __________ Ties shoes____

Toileting skills: Please describe your child's level of independence, frequency of any bedwetting, frequency of daytime accidents both bladder and bowel __________________________________
____.

Bath Time: What does your child like/dislike about bath time and what is their level of independence?
____
____

Hygiene Skills: Tell us the level of independence and behavior for your child for each;

Brushing their teeth:____
____

Brushing their hair: ____
____

Washing hands and face: ____
____

Social /Play: Describe how well your child makes transitions between people and new environments. What level of independence do they have with transitions? Is there a need for advanced preparations and transitional objects? ____
____
____

Tell us about your child's toys and favorite play activities.___________________________________
____

Describe your child's behavior on outings such as shopping, restaurants, parties and family trips. Indicate if your child has difficulties with any of these activities and explain why you think they are difficult for your child.____
____
____

School/Productive Activities:

Name of current preschool/school___________________________ Present Grade Level___________

Does your child experience any difficulties in school?_______________________________________

What appears to be your child's dominate hand for small motor activities?
Right_________ Left__________ Shows no preference____________

Describe how well your child performs fine/visual motor activities, such as holding a crayon/pencil for writing and drawing letters. Is your child able to use scissors for cutting paper? _________________
____

Does your child receive any special services? Please list and include the frequency of each.
(i.e. speech therapy, occupational therapy, physical therapy) ________________________________
____

Permission to Evaluate and Provide Therapy

Please complete the bottom portion of this form to grant permission for Advantage Therapy, LLC to evaluate your child's current speech and language/ occupational skills and provide treatment as needed.

I,________________________ authorize Advantage Therapy, LLC to evaluate and
(parent/guardian)
provide the recommended speech and language/occupational treatment/therapy to______________________.
(client)
Therapy/treatment is contingent upon the results of the evaluation and the impending recommendation of the responsible speech language/occupational therapist.

______________________________ ________________________________
Parent/Guardian Signature Print name of parent/guardian

Date_______________________________

Advantage Therapy, LLC's Insurance Acceptance Policy

Attn: Concerned Parent

We understand that you are seeking speech therapy services for your child and you would like us to bill your insurance provider directly. While we are happy to proceed with this billing option, you may be responsible for a co-pay which will be billed monthly. You will also be considered responsible for any deductibles that may apply. Furthermore, if the insurance provider denies or fails to pay any claims, you as the parent or guardian will be responsible for payment of the services.

I have read and understand Advantage Therapy's Insurance Acceptance Policy and accept all terms and conditions.

_____________________________________ ____
Child's Name Parent/Guardian Signature

____
Date of Signature

HIPAA Authorization Form

CHILDS NAME (please print): ______________________________DATE OF BIRTH: ____________

INDIVIDUALS ADDRESS____

I hereby authorize use or disclosure of protected health information about my child as described below.

1. Advantage Therapy, LLC and its employees are authorized to use or disclose health information that is pertinent or required for Speech-Language/Occupational Therapy purposes.

2. Advantage Therapy, LLC may disclose health information considered pertinent to Speech-Language/Occupational Therapy to a patients physician, teacher, or social worker.

3. I understand that Advantage Therapy, LLC will be disclosing protected health information to a patients physician, teacher, and social worker (where necessary) and also understand that the information used or disclosed may be subject to re-disclosure by the individual or facility receiving the information.

4. I may revoke this authorization by notifying MELISSA PETERS AND OR ADVANTAGE THERAPY, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. This authorization expires when a patient is discharged by Advantage Therapy, LLC or receives a written desire to revoke it.

______________________________ ______________________________

Parent /Guardian Signature Date of Signature

Missed Appointments and Cancellation Policies

We request that you notify us at least **three** hours prior to your appointment if you need to cancel or reschedule. All therapists have a cell phone and should be called directly to cancel an appointment, if you can not locate your therapist's number call the office and they can give it to you.

If you fail to call or come in for an appointment it is considered a ***Missed Appointment***.
Missed appointments are very disruptive to the effectiveness of your child's treatment, and to the therapist's schedule. We reserve the right to charge you a $50.00 missed appointment fee; insurance companies do not cover this fee.
If your child misses 3 or more consecutive therapy sessions; our office reserves the right to place your child's services on hold until the scheduling difficulties are resolved or to discontinue services if necessary.

Your cooperation in complying with these guidelines is appreciated. We believe that a consistent schedule is very important to your child's progress.

____
Child's Name

____________________________________ ____________________
Parent/Guardian Signature Date