# Speech Therapy Solutions Montana

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**Today's Date:** _____

Child's Name: _____ Birthdate: _____ Sex: ☐ F ☐ M
Physical Address: _____ Phone: _____ Text: ☐ Y ☐ N
_____ Carrier: _____

**Guardian/Responsible Party Information:**

Please circle: Mother Step Mother Guardian
Name: _____
Birthdate: _____
SS#: _____
Phone: _____
Carrier: _____
E-mail: _____
Address - if not the same as client:
_____
_____

Is this person financially responsible? ☐ Y ☐ N
Does the client live with this person? ☐ Y ☐ N
May we leave a detailed message via (check all that apply)
Text: ☐ Y ☐ N Email: ☐ Y ☐ N Phone: ☐ Y ☐ N

Please circle: Father Step Father Guardian
Name: _____
Birthdate: _____
SS#: _____
Phone: _____
Carrier: _____
E-mail: _____
Address - if not the same as client:
_____
_____

Is this person financially responsible? ☐ Y ☐ N
Does the client live with this person? ☐ Y ☐ N
May we leave a detailed message via (check all that apply)
Text: ☐ Y ☐ N Email: ☐ Y ☐ N Phone: ☐ Y ☐ N

**Emergeny Contact:** (Not listed above)

NAME: _____ PHONE: _____

Doctor's Name: _____ Doctor's Phone: _____

**Child lives with (check one):**

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Step Parent ☐ Other: _____

**Other children in the family:**

| Name | Age | Sex | Grade | Speech/Hearing Problems |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Child's race/ethnic group:**

☐ Native American ☐ African-American ☐ Caucasian, Non-Hispanic
☐ Hispanic ☐ Asian or Pacific Islander ☐ Other: _____

## Speech • Language • Hearing

**Is there a language other than English spoken in the home?** ☐ Yes ☐ No

If yes, which one? _____

Does the child understand the language? ☐ Yes ☐ No

Does the child speak the language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, when and where: _____

What were you told? _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, when and where: _____

What were you told? _____

_____

_____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, when and where: _____

What was he/she working on? _____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

## Birth History

Was there anything unusual about the pregnancy and/or birth? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If the child stayed at the hospital, please describe why and how long: _____

_____

_____

## Medical History

Has your child had any of the following:

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ ear infections
- ☐ How often?
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems
- ☐

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Please list any and all medications your child takes regularly: _____

_____

_____

## Developmental History

Please list the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child choke on food or liquids? ☐ Yes ☐ No
Does your child currently put toys/objects in his/her mouth? ☐ Yes ☐ No
Does your child brush his/her teeth or allow brushing? ☐ Yes ☐ No

## Current Speech • Language • Hearing

Does your child…

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates using…

- ☐ body language
- ☐ sounds (vowels, grunting)
- ☐ words (shoe, doggy, up)
- ☐ 2 to 4 word sentences
- ☐ sentences longer than 4 words
- ☐ other _____

Behavioral characteristics of your child…

- ☐ cooperative
- ☐ attentative
- ☐ willing to try new activities
- ☐ plays alone for reasonable length of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

## School History

If your child is in school, please answer the following:

Name of school currently attending: _____

Grade: _____

Teacher's name: _____

Has your child repeated a grade? _____

_____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subjects? _____

_____

## Insurance Information

**PLEASE FILL OUT COMPLETELY IF YOU WOULD LIKE THIS EVALUATION AND/OR TREATMENT PROCESSED THROUGH YOUR INSURANCE COMPANY:**

**Primary Insurance Information:**

Ins. Company: _____ Co-Payment Amount: $ _____
Plan Type: _____ Ins. Phone: _____
Primary ID: _____ Address: _____
Policy/Group #: _____ _____
Plan/Program: _____ _____

Subscriber: _____ Relation to patient: _____
Birth Date: _____ SSN#: _____

**Secondary Insurance Information:**

Ins. Company: _____ Co-Payment Amount: $ _____
Plan Type: _____ Ins. Phone: _____
Primary ID: _____ Address: _____
Policy/Group #: _____ _____
Plan/Program: _____ _____

Subscriber: _____ Relation to patient: _____
Birth Date: _____ SSN#: _____

# Responsible Party/Payment Information

**Who is financially responsible?**

Full Name: _____ Birthdate: _____ Sex: ☐ F ☐ M

Relation to patient: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

_____ Cell Carrier: _____ (for text reminders)

SSN #: _____ Insurance: _____

Email: _____

* May we leave a detailed message via (check all that apply): Text: ☐Y ☐N Email: ☐Y ☐N Phone: ☐Y ☐N

I, _____, agree to pay all co-payment amounts due at time of service. I understand that sending a claim for treatment rendered to my insurance company is a service generously provided by Speech Therapy Solutions Montana. However, in the event my insurance company does not respond or submit payment, it is my responsibility to contact my insurance company and discuss my coverage and payments. I also understand that I am fully responsible for any and all treatment balances not covered, or not paid for by my insurance company. I understand that my lack of payment may result in late fees and an interruption and/or cancellation of treatment.

_____ _____

(Signature of responsible party) (Today's Date)

**Automatic Payments:**

* Use our secure system to easily set up monthly, weekly or per visit payments:

Automatically charge co-pay and/or treatment balance at time of service? ☐Y ☐N

Co-pay amount to be charged per visit: $_____

Automatically charge co-pay and/or treatment balance each week? ☐Y ☐N

Weekly amount to be charged: $_____ Day of week to charge: _____

Automatically charge a monthly amount to cover all co-pay and/or treatment balances? ☐Y ☐N

Please charge balance due each month on this date: _____

**Credit Card Information:**

Card Type: ☐ Visa ☐ American Express ☐ Discover ☐ MasterCard

Card #: _____ Expiration Date: _____

3 Digit Code (found on back of card): _____

I authorize Speech Therapy Solutions Montana to automatically charge my credit card per the instructions I have given above.

Signed: _____ Date: _____

## Additional Comments