1448 E Center Street, Suite G
Pocatello, ID. 83201
Phone: (208) 547-7145 / Fax (844) 671-7145
Email: kids@spotkids.org

SPEECH AND OCCUPATIONAL THERAPY FOR KIDS

Today's Date_____ Physician_____
Child's Name _____ Date of Birth _____
Parent's Name(s) _____
Physical Address _____
Mailing Address _____Zip _____
Home Phone _____ Cell _____
Email _____ Preferred Method of Contact _____
Child's Medical Diagnosis, if any _____
Day Care/Babysitter _____
Language(s) other than English that the child understands and/or speaks_____
What School does your child attend? _____ Grade?_____
Please list parents, siblings and their ages, and any other person living in your home:

_____ _____ _____
_____ _____ _____
_____ _____ _____

What concerns you most about your child's speech-language or daily activity skills (fine motor, gross motor, dressing, behavior)?

_____
_____

If therapy is recommended, what would you like your child to be able to do in 6 months time?

_____
_____

Please check the boxes below that apply to your child:

Pregnancy & Delivery

☐ Child adopted
☐ Complicated Pregnancy
☐ Normal Pregnancy
☐ Complicated Delivery
☐ Normal Delivery
☐ Baby stayed in NICU
☐ How long?_____
☐ Oxygen was needed after birth
☐ Feeding difficulties as an infant
☐ Breast fed
☐ Bottle fed
☐ Failure to thrive

Health History

☐ Major health problems
☐ Long hospitalizations
☐ Loss of consciousness
☐ Seizures
☐ Vision impairment
☐ Hearing impairment

☐Wears hearing aids right_____left _____binaural _____
☐Cochlear implant(s) right _____ left _____ binaural _____ when implanted_____
☐Failed a hearing screening or evaluation
☐Concerned that there is a hearing problem
☐Frequent ear infections
☐PE tubes – year inserted _____
☐Has seen an Ear, Nose, Throat Specialist
☐Tonsils/ ☐adenoids removed (check which), when_____
☐Taking medications (please list)_____
☐Allergies
☐History of speech/language or developmental delays in family members
☐Has had a speech/language or occupational evaluation or therapy before
☐Where at (evaluation) _____
☐Has had other therapies (what / where) _____
_____

Milestones:
☐Motor skills developed on time (sat, crawled, walked)
☐Motor skills delayed
☐First words said on time (approx. 12 mos.)
☐First words said late
☐Combined 2 words on time (approx. 2 yrs.)
☐Combined 2 words late
☐Drinking from a cup & using utensils by self
☐Potty trained or showing interest & trying
☐Having trouble potty training/not interested
☐Dressing self or helping with dressing self
☐Not currently dressing or helping dress self
☐Feeds him/herself from plate to mouth using utensils

FOR CHILDREN UP TO 3 YEARS OLD
Check all the ways your child communicates his/her wants and needs
☐Uses gestures or points to desired objects
☐Uses noises/grunts or cries
☐Uses some sign language
☐Uses single words most of the time
☐Uses phrases or short sentences
☐Understands much of what is being said
☐Has difficulty understanding what is said
☐Identifies familiar objects when named
☐Understand & is able to follow directions
☐Has difficulty understanding & following directions
☐How many words does your child use consistently? Check one:
☐Less than 10 ☐10-25 ☐25-50 ☐more than 50

FOR CHILDREN 3 YEARS AND OLDER
Check all of the areas you are concerned about
☐Articulation (how sounds are produced)
☐Intelligibility (how well you understand the child)
☐Syntax (grammar & sentence structure)
☐Comprehension (understanding what is being said, answering questions, following directions)
☐Fluency (stuttering)
☐Pragmatics (social skills, peer interaction)
☐Overall learning ability

Child's Name:_____

FOR ALL CHILDREN

☐ At what percent do you understand your child's speech? (Check one) ☐25% ☐50% ☐75% ☐95-100%

☐At what percent do others (grandparents, caregivers, friends) understand your child's speech? (Check one)

☐25% ☐50% ☐75% ☐95-100%

☐Follows a daily routine:

☐Picky eater / food refusals

☐Does not eat a variety of foods/textures

☐Overstuffs mouth when eating

☐Difficulty chewing

☐Difficulty swallowing or chokes frequently

☐Puts objects or hands in mouth frequently

☐Drools excessively

☐Thumb sucking habit

☐Does not tolerate teeth brushing very well

☐Sensitivity to ☐touch, ☐noise, ☐light, ☐sound, ☐smells - please check which ones

☐Refuses to nap (3 years or younger)

☐Trouble falling asleep / staying asleep

☐Night terrors

☐Mouth breather (open mouth) or snoring

☐Easily distracted

☐Difficulties with social skills or playing with peers

☐Difficulties with imaginative play

☐Tends to control the play context with others

☐Difficulty separating from parent/caregiver

☐Difficulty changing routines

☐Difficulty going from one thing to the next

☐Symptoms of anxiety

☐Short attention span or trouble concentrating

☐Impulsive (doing things quickly without thinking)

☐Lack of awareness of danger

☐Excessive tantrums for age

☐Other behavior problems

☐Trouble with following adult direction

☐Engages in excessive movement than same age peers

☐Engages in touching, smelling, looking, etc. at certain objects for prolonged periods

☐Fine motor difficulties (ie. fumbling objects in hand, trapping small objects against body)

☐Impaired handwriting legibility

☐Difficulty with gross motor tasks (ie. Uncoordinated movements, difficulty performing movements) Speech/

☐language problems that cause teacher/sitter problems

☐Speech/language problems causing frustration/behavior problems

☐Other Behavior Problems (Please specify):

_____

_____

_____

☐What type of play does your child participate in? (Likes, Dislikes)

_____

_____

☐Additional information you want to share

_____

_____

Child's Name:_____

SPEECH BLOSSOMS is now doing business as

Please 'like us' on our new FaceBook page
SPOT Blossoms, LLC

Speech and Occupational Therapy for Kids

We occasionally take photos or short videos for treatment and assessment purposes. Below is permission or decline for SPOT Blossoms to use these photos / videos for educational purposes and legal promotion of our clinic.

Mark <u>ONLY ONE</u> Line Below and Fill one Only One section Below

- -

Permission to Use or Not Use Photograph

SPOT Blossoms, its representatives and employees, has the right to take photographs / video of my child. I agree that SPOT Blossoms may use such photographs of my child with or without my name and for any lawful purpose, including for example, such purposes as education, publicity, illustration, advertising, and Web content.

________ I have read and understand the above and give permission for the above use.

________ Mark here if you DO NOT want your child's picture or video taken and used for Publicity but grant permission to use photos or videos for treatment or assessment purposes.

________Mark here is you DO NOT want your child's picture or video for any purpose.

Signature of Legal Guardian____

Printed Name____

Child's Name____

Child's Date of Birth ____

Date____

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SPEECH AND OCCUPATIONAL THERAPY FOR KIDS

PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
YOUR PRIVACY RIGHTS

Acknowledgement That You Received and Understand Your Privacy Notice.
Speech Blossoms, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor
- Your medical history
- Your test results
- Treatment notes
- Insurance information

We are required by law to provide you with a copy of your privacy notice. This notice tells you how your health information may be used or shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been provided a copy of our **HIPAA privacy notice** and our **Payment / Cancellation Policy** and that you understand the privacy policies disclosed within.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the undersigned physician or supplier for services described: Speech and/or Occupational Therapy. I also request payment of government benefits either to myself or to the party who accepts assignment as listed below:

Speech Blossoms, LLC, dba: SPOT Blossoms
1448 E Center Street, Suite G Pocatello, ID 83201

Client Name (print): _____

Client D.O.B: _____

Parent / Legal Guardian Name (print): _____

Parent / Legal Guardian Signature: _____

Date: _____