HEARING AND SPEECH CENTER OF FLORIDA, INC.

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☐ **SPEECH AND LANGUAGE EVALUATION**

☐ **OCCUPATIONAL THERAPY EVALUATION**

PRELIMINARY INFORMATION: The information obtained from the following questions will assist us in formulating a diagnosis. Please answer all questions as thoroughly as possible, using additional space on the back of these pages if necessary. A written summary of our recommendations arising as a result of this Clinical Evaluation will be provided - when requested - to proper agencies.

CLIENT'S NAME_____ Nickname: _____ Date of birth: _____

Address:_____ City: _____ Zip: _____

Home Phone: _____ Work phone: Father:_____ Mother: _____

FATHER'S NAME _____ Age_____ Occupation: _____

MOTHER'S NAME_____ Age_____ Occupation: _____

Birthplace of child: _____ Birthplace of parents: _____

Who will accompany the applicant? _____

Who referred you to this clinic?_____

FAMILY HISTORY:

Parental status: ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Is this an adopted or foster child? ☐ yes ☐ no If yes, then at what age?_____

With whom does the applicant live? (List all persons)_____

If both parents work, who cares for the child and where?_____

BIRTH HISTORY:

Health of mother during pregnancy_____

The child was mother's (Circle one) 1, 2, 3, other #_____ pregnancy.

Length of pregnancy: ☐ Premature ☐ Full term

Medication during pregnancy? ☐ yes ☐ no If yes, reason and type_____

Delivery: ☐ Normal ☐ Instrument ☐ Breech ☐ Caesarian

Condition at birth: ☐ Jaundiced ☐ Blue ☐ Respiratory distress ☐ Other _____

Length of labor _____ Anesthetic used_____ Birth weight_____

Physical abnormalities: ☐ yes ☐ no If yes, please explain _____

Feeding: ☐ Breastfed ☐ Bottlefed ☐ Nutritional disturbances_____

SPEECH HISTORY:

Age when first began: Babbling _____ Using single words_____

Using 2-3 word phrases_____ Using sentences_____

Rate of speech development: ☐ Fast ☐ Average ☐ Slow

Clarity of child's speech: ☐ Below average ☐ Average ☐ Above average

Age when speech and/or hearing deficit was discovered_____

Under what circumstances?_____

Describe child's speech and/or hearing problem as best as you can_____

_____

Parent's opinion of possible cause_____

Child's feeling about this problem_____

Is child?: ☐ Talkative ☐ Quiet ☐ Average

Is any foreign language spoken at home? ☐ yes ☐ no If yes, what language(s)?_____

Does your child speak both languages? ☐ yes ☐ no Explain_____

Do any members of the family have a speech or hearing problem? ☐ yes ☐ no

Describe_____

Has your child received speech therapy previously? ☐ yes ☐ no

Dates and locations:_____

HEARING HISTORY:

Has your child ever been treated for ear infections? ☐ yes ☐ no When?_____

Which ear?_____ How was it treated? ☐ Medication ☐ PE Tubes

Was your child examined by an Ear Specialist (Otologist) ☐ yes ☐ no If yes, who?_____

Do you suspect your child has a loss of hearing? ☐ yes ☐ no

If yes, then what made you aware of the hearing problem and when did you first notice it?_____

Has your child been diagnosed with a hearing impairment/hearing loss? ☐ yes ☐ no

If yes, then what was the diagnosis given? _____

Does your child seem to hear better in one ear than the other? ☐ yes ☐ no Which ear?_____

At present time, does your child's hearing seem to be: ☐ better ☐ worse ☐ same as usual

Is your child wearing a Hearing Aid(s)? ☐ yes ☐ no Make and Model_____

Has your child had a hearing test in the last 12 months? ☐ yes ☐ no

If yes: When/Where/Results?_____

Does your child communicate ☐ orally ☐ with signs ☐ using total communication

CHILDHOOD DISEASES: State age, severity and after effect.

Chicken pox _____ Measles_____

Rubella_____ Convulsions_____

Meningitis_____ Pneumonia_____

Asthma_____ Allergy_____

Influenza_____

Surgeries/Injuries/Illnesses:_____

_____

GENERAL DEVELOPMENT:

Present physician:_____ Phone #: _____

Address: _____

Height_____ Weight_____ Current health: ☐ good ☐ fair ☐ poor

Age of: sitting_____ crawling_____ walking_____ self-feeding_____ dressing_____ toilet training_____

Comparison with other children_____

Current behaviors (Please check if answer is yes):

☐ Nervousness ☐ Sleeplessness ☐ Nightmares ☐ Bedwetting

☐ Shyness ☐ Eating problems ☐ Extreme fears ☐ Thumbsucker

☐ Pacifier use ☐ Bottle use ☐ Nailbiting ☐ Temper tantrums

☐ Over active ☐ Destructiveness ☐ Self-abusive ☐ Difficulty with transitions

☐ Poor eye contact ☐ Social withdrawal ☐ Preference for older children

☐ Preference for younger children ☐ Other _____

EDUCATIONAL HISTORY:

Name and address of present school_____

At what age did child start school_____

Is your child enrolled in Exceptional Student Education (ESE) classes? ☐ yes ☐ no

If yes, please describe_____

Highest grade completed_____ Teacher's Name_____

Academic performance: ☐ Below average ☐ Average ☐ Above average

Grades failed_____ Child's attitude towards school_____

Are there any difficulties at school (subjects, behavior, etc.)? _____

Does your child receive any of the following services in school? ☐ Speech/Language ☐ OT ☐ PT

If your child is receiving services, with whom? _____

READING:

Does your child show visual deficits? ☐ yes ☐ no Describe_____

Does the child show evidence of reading difficulty? ☐ yes ☐ no How and since when?_____

Does your child receive tutoring at school/home? ☐ yes ☐ no

If so, by whom and for what subject(s)?_____

What is the child's attitude towards reading?_____

Does he enjoy recreational reading? ☐ yes ☐ no How much?_____

SPECIAL TESTS: Has your child ever been given a:

Psychological test_____Age_____Date_____Where_____

Neurological test_____Age_____Date_____Where_____

Was a diagnosis given? ☐ Autism Spectrum ☐ ADD/ADHD ☐ Fragile X Syndrome

☐ Learning Disability ☐ Other _____

Has your child been seen by any other agency? ☐ yes ☐ no

If yes, please list them:_____

Date:_____ Parent/guardian_____

THIS PORTION MUST BE FILLED OUT IN ORDER TO RECEIVE SERVICES

RESPONSIBLE PARTY:

Some, but not all, insurance companies pay for SPEECH evaluations/therapy, HMOs and PPOs often require a co-payment at the time of the visit. Most insurance companies DO NOT pay for evaluations, and speech follow-up visits, for Medicaid or Medicaid covered group plans the patient must present a current card at the time of service so we can check that they are eligible for services. If you need a written referral for services from your insurance company it must be presented at the time of the visit, or you will be required to pay for the service yourself and then attempt to be reimbursed by your company.

_____ _____

Signature of parent or guardian Date

PAYMENT AGREEMENT:

"I agree to pay the Hearing and Speech Center of Florida, Inc. any and all charges incurred by visits and services rendered which are not covered by my insurance company."

_____ _____

Signature of parent or guardian Date

_____ _____

Insurance Company Insurance Policy #

RELEASE OF INFORMATION AND CONFIDENTIALITY POLICY

All information regarding you (your child) is completely confidential. No information will be released without your signed permission.

"I Hereby give permission for the Hearing and Speech Center of Florida, Inc. to release/request information regarding:_____ for treatment and/or reimbursement for services rendered."

(Name of client)

_____ _____

Signature of parent or guardian Date

INSURANCE STATUS

I certify that _____ is not eligible for or is not receiving Medicaid,

(Name of client)

Medicaid Waiver, or any other insurance covering services covered by the Hearing and Speech Center of Florida.

_____ _____

Signature of parent or guardian Date