SpeechBuilders, LLC
Speech and Language Therapy
2515 East Semoran Blvd, Apopka, FL 32703
Office: 407.703.2711 Fax: 407.910.2923
www.speechbuilders.org

Case History Form

(Please completely fill out this form)

Patient_____ DOB_____ Age_____

Parent(s)/ Guardian(s)_____

Address_____City_____State/Zip_____

Email Address_____(by giving us your email address you will be signed up to receive our weekly email newsletter)

Phone_____ Please initial _____ if we have permission to text with therapy progress and updates)

Insurance_____ Member ID #_____

Doctor_____ Phone_____

School_____ Grade_____

Phone Number_____

Reason for Evaluation_____

AUTHORIZATION

I authorize SpeechBuilders, LLC to evaluate my child (listed above). I understand that I will be responsible for payment at time of service. CANCELLATIONS MUST BE CONFIRMED WITH YOUR CLINICIAN AT LEAST 4 HOURS IN ADVANCE. I authorize written and verbal communication between SpeechBuilders, LLC and my child's doctor or teacher for coordination of care. I authorize verbal and written communication between SpeechBuilders, LLC and my child's school for coordination of care and scheduling visits. I authorize verbal and written communication between SpeechBuilders, LLC and previous speech, occupational or behavior therapists for coordination of care. I understand that I am responsible for payment of services not covered by insurance.

Parent/Guardian Signature_____
Printed Name of Parent/Guardian_____ Date_____

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Background Information

What is your goal for this therapy experience/evaluation? What specific questions do you have?

_____

_____

Language(s) your child is exposed to at home and school?_____

Does your child currently receive speech therapy? _____

If so, where? _____ How often? _____

Does your child have a history of ear infections?_____

If yes, please give details including if tubes were put in_____

Do you have any concerns about your child's hearing?_____

When is the last time that your child's hearing has been tested? _____

What were the results?(circle one) PASS FAIL

Are there any other family members with a history of developmental concerns (e.g. speech issues, learning deficits, ADHD)?_____

Does your child have any trouble eating, chewing, swallowing or is a picky eater? If yes, please explain_____

Prenatal/Birth History

Was pregnancy full term or premature? (Circle one)

Were there any complications during pregnancy or delivery?

If yes, please explain_____

Type of Delivery: Vaginal_____ C-Section_____ Breech_____

Number of children_____ Ages of Children_____

List any medications currently being taken by child:_____

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Therapy History

Has your child ever been treated/tested by a speech therapist before?_____

If yes, when and how long?_____

Is your child currently receiving therapy from another specialist? i.e., behavior therapy, ABA therapy, occupational therapy, physical therapy, nutritionist, etc.? _____

If yes, what kind of specialist?_____

Developmental History

Developmental Milestones -give approximate age when child began to do the following:

Sat Alone_____ Crawling_____ Walking_____ Running_____ Hold Bottle_____

Babbling_____ First Words_____ Sentences_____ Dressing Self_____

Overall do you feel like your child's development was delayed or normal? (Circle one)

Child lives with (circle one):

Birth Parents Foster Parent(s) One Parent Adoptive Parent(s)

Parent and Step Parent Other_____

Is there anything else you want us to know?

_____

_____

_____

_____

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Patient Expectations and Attendance Policy

1. **Be consistent.** We believe that the only way to see progress is for therapy to be consistent. That means coming to the office every week to your scheduled appointments or making sure your child is at school when the therapist is scheduled to be there.
2. **Therapy is up to you.** We recommend how many sessions we think your child needs. It is your final decision whether to participate in therapy and how often. We ask that you look at your schedule and find how many therapy sessions work for you.
3. **Missed appointments:** We work very hard to plan an individualized therapy session for your child. After 2 missed appointments that are not made up during the same week or 2 no-shows, we are unable to hold your spot on our schedule. You will be removed from our schedule and asked to call in weekly to make your appointments until your child is reevaluated. If you miss another appointment without making it up that week or have a no-call/no-show, we will discontinue therapy.
4. **Come to therapy on time.** If you are more than 15 minutes late for an appointment, we consider it a no-show. We tend to schedule back-to-back appointments so we are unable to extend a therapy session if you come late.
5. **Leaving the premises:** If you choose to leave the premises while your child is in a session please return 5-10 before the session ends (the session ALWAYS ends 5 min early). If the session ends and you have not returned, we ask that you remain on premises for ALL sessions. Also, in leaving the premises you are doing so at your own risk.
6. **Rescheduling Appointments:** Please call at least 4 hours in advance to reschedule or cancel an appointment any thing less is considered a no show.
7. **Keep them home if they are sick.** We ask that you make up the missed visit in the same week.
8. **Therapy at school:** If the therapist sees your child at school, the therapist will call you to let you know when they will be seeing your child. **Patients seen at school need to be at school by 9am.** If your child is sick or absent, please call the therapist directly to let them know. If the therapist comes 2 times and he/she is absent, we have the right to discontinue therapy.
9. **Keep us aware of changes.** If there is a change in address, pediatrician, or insurance coverage, we expect that you will inform us.
10. **See your doctor.** We expect you to keep your child under the care of your pediatrician while receiving speech therapy. *All our evaluations must be signed by your child's pediatrician.*
11. **Talk to us.** If you have any concerns about your child's progress or therapy, we expect that you will let us know. We are a team and your child's progress is the most important thing to us.

Child/Patient Name: _____

Parent Signature: _____

Printed Name: _____ Date_____

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Acknowledgment That You Have Reviewed Our HIPAA Privacy Notice

SpeechBuilders, LLC is required by law to keep your health information safe. This information may include:

*Notes from your doctor or other medical provider

*Your medical history

*Your test results

*Treatment notes

*Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and 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 received our privacy notice and patient rights.

Print Patient Name_____

Patient or Parent/Guardian Signature_____

Patient or Parent/Guardian Printed Name _____

Date_____