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CONDITIONS OF ADMISSION TO AUSTIN'S COMMUNICATION STATION INC.

Release of Information: Austin's Communication Station Inc. may disclose all or any part of the patient's record to any person or corporation which is involved in the client's plan of care or may be liable under a contract to the agency or to the patient or to a family member. The agency may disclose either in writing or by oral communication any or all of the patient's record.

Treatment Consent: The patient is under the control of their physician and the undersigned consents to any treatment or procedures rendered the patient by Austin's Communication Station Inc. under the general and specific instructions of the physician. It is further understood that Austin's Communication Station Inc. is authorized to carry out all instructions of the patient's doctor and that Austin's Communication Station Inc. is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Austin's Communication Station Inc., to provide me with the treatment and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize my insurance company to disclose information regarding my medical coverage, but not limited to verification of my insurance number, effective dates and type of coverage.

The undersigned certifies that he/she has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent, to execute the above and accept its terms. It is further understood that this release remains in effect throughout the duration of the patient's therapy at Austin's Communication Station Inc., unless revoked.

_____	_____	_____
Signature of person authorized To sign in Lieu of patient	Date	Witness

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FINANCIAL RESPONSIBILITY FORM

Patients Name: _____

We will collect insurance information from you so that we can contact your insurance company and investigate the benefits your particular insurance plan may have for speech therapy service. Austin's Communication Station Inc. will file insurance claims with some insurance carriers, but under most insurance plans Austin's Communication Station Inc. is an out-of-network speech therapy provider.

Please note that clients are required to notify us of any insurance companies and any information changes that they have coverage with, while receiving services from Austin's Communication Station Inc. Clients will be held liable for charges if they do not disclose their correct coverage.

Please be sure to provide Austin's Communication Station Inc. with a copy of your insurance card each time you receive a new card and/or your insurance information changes.

The benefit details are an estimate given to us by your insurance. The benefit amounts given to us are not a guarantee of payment. Please follow up with your insurance if you have any questions. As a courtesy, our staff will try to make requests for additional visits as more become necessary. Also, as a courtesy, we will check your benefits, and we file claims for some insurance companies, but for assurance of payment, *please contact your insurance's customer service department. Please obtain details about specific coverage for Speech Therapy under your plan*. Sometimes, our billing staff will request for you to contact your insurance company if the insurance company requires additional information from you to process the claims.

All parents are expected to know and understand their coverage and benefits for therapy services. Although we will verify insurance benefits prior to your first appointment, you may also check your benefits by calling the phone number on your insurance card and speaking with a representative from the insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. A quote of benefits from your insurance company is not a guarantee of payment. In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.

Austin's Communication Station Inc. will file all insurance claims for health insurance plans that it is an in-network provider. All other insurance claims are the client's responsibility to file accordingly. Austin's Communication Station Inc. will provide appropriate invoices and information in order for clients to file with their insurance carriers. However, all correspondence with insurance companies for which Austin's Communication Station Inc. is not in-network is the responsibility of the client.

We will do our best to answer any insurance related questions. Calling your insurance company directly is frequently required and the most accurate way to get any questions/concerns answered. Any follow-up regarding non-payment after our initial appeals process is your responsibility. **If payment is not issued by the insurance company within 60 days of initial filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals.** Since your agreement with your insurance carrier is a private one, we may not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. Please understand that if your insurance company delays payment or is waiting on additional information before they

render payment, and the balance due is past 60 days, the balance is your responsibility and is due immediately. At this time, if payment is not made immediately, services will be placed on hold until the balance is paid in full.

If we are not filing insurance for you, payment for services will be negotiated prior to your first visit at the clinic.

Co-insurance will be invoiced monthly and due within 14 days after the date of invoice.
However, if this policy is abused and the client does not pay within 14 days of being invoiced, Austin's Communication Station, Inc. reserves the right to remove this privilege and payment will be due prior to EACH visit.

Any portion of the therapy fees not reimbursed by your insurance company is your responsibility.

You are responsible for payment of any no-shows for appointments, and short notice or too many cancellations, as insurance companies will NOT reimburse any of these charges. Please see the cancellation and attendance section of this packet for specific details.

Austin's Communication Station Inc. will provide in-home and school consultations at the request of the client. These services are not covered by insurance and therefore you will be billed at the standard hourly fee for the clinic. Patients are responsible for full payment of this service prior to the consultation.

Our office accepts check, cash, and some debit/credit cards.

For returned checks we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms the patient understands that our office may report to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees. The patient is ultimately responsible for all fees for services.

I have read, understood and agreed to the above financial policy for payments of professional fees.

I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers. The undersigned certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms.

_____	_____	_____
Responsible party and/or trustee of patient's funds	Date	Austin's Communication Station Inc. Representative Signature

ASSIGNMENT OF BENEFITS

I hereby authorize the _____, Company to pay directly to Austin's Communication
Insurance Company Name
Station Inc., all benefits that may be due to me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with aforementioned insurance company. I understand that Austin's Communication Station Inc., which has accepted assignment, has the same right as I do to appeal carrier's determination.

_____	_____	_____
Patient or Patient's agent	Date	Austin's Communication Station Inc. Representative Signature

Revised December 1, 2014

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Attendance, Cancellations and Rescheduling

Attendance is a key factor in the success of your program and in our ability to help your child and you succeed. It is very important for your child to attend therapy regularly and to do his/her homework. We designate your regularly scheduled time to your child. Your therapist plans activities specifically for your child and commits a portion of his/her time.

CANCELLATIONS

Austin's Communication Station (ACS) Inc. requires a 24-hour cancellation notice for therapy sessions and a 48-hour cancellation notice for evaluations. These timeframes allow us time to give your designated appointment time to someone who is waiting for an appointment or needs to make up an appointment. You can cancel appointments via phone 512-610-1190 (leaving a message is sufficient to provide notice of cancellations), or email at info@AustinsCommunicationStation.com.

If you cancel with less than 12 hour notice, a $50 cancellation fee is charged to you and is due upon your next monthly invoice. *Insurance companies do not cover cancelled appointments*. If you reschedule your appointment it will nullify the cancellation fee as long as the appointment takes place within 14 business days of your cancelled appointment. This rescheduling is subject to availability of the therapists' schedules.

If client has excessive cancellations:

- If your child attends therapy 1-2 sessions a week—you are allowed 3 cancellations in 6 month period: (Jan 1-June 30; and July 1-Dec 31)
- If your child attends therapy 3 or more sessions a week—you are allowed 5 cancellations in a 6 month period: (Jan 1-June 30; and July 1-Dec 31)

Regardless of advanced notice, a $50 a session charge will be imposed if the above cancellation limits are exceeded and if session is not made-up within 14 business days of your cancelled appointment. If you cancel but you are able to reschedule your appointment and attend the rescheduled therapy session, it will nullify this $50 charge.

***This rescheduling is subject to availability of the therapist's schedules.*

Revised December 1, 2014

NO SHOWS

If you do not call and "no show" for an appointment you will be charged a $75 fee and this fee is due on your next monthly invoice.

You may reschedule a no show appointment nullifying the cancellation fee by rescheduling your appointment to take place within 14 business days of the appointment you missed. *Insurance companies do not cover no show charges.* Two, consecutive No Show appointments without contacting our office, constitutes removal from the schedule.

ACCIDENTS AND ILLNESS HAPPEN

Accidents and illness may strike at the last minute leaving no choice but to cancel your appointment with less than 12 hours notice. If you or your child is sick, you may provide a physician's note corroborating the illness and you will not be charged. We will be happy to reschedule the appointment when you or your child gets well.

Please remember that children cannot attend therapy services if they have an infection or contagious disease (example: fever, chicken pox, measles, thrush, impetigo, pink eye, strep, hepatitis, stomach virus, vomiting, diarrhea etc). Also, if your child has been kept home from school due to illness he/she should not attend therapy. It is very important that we watch out for the health of other children and our therapists.

Should your therapist become ill, you will be scheduled at your normal time with another therapist or notified and rescheduled when there is an available time.

RESCHEDULING MISSED APPOINTMENTS

You may make up your missed appointment within 14 business days at no charge. We will try to schedule you with your regular therapist. If this is not possible, your make up appointment may be scheduled with another therapist. The therapist seeing your child for your make-up appointment will contact your regular therapist about your treatment goals and activities prior to your make-up appointment.

**Rescheduling of appointments is always subject to availability of the therapists.

I have read and understand the above cancellation and attendance policy. I agree to abide by the conditions listed above.

_____
Childs Name

_____ _____
Signature of legal representative of child Date

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PHOTOGRAPH AND VIDEO RELEASE FORM

I hereby authorize Austin's Communication Station Inc. to photograph or video my child for the purposes of treatment, education and professional reasons. I also understand that my child may be in group pictures or video that may also be viewed by others outside of Austin's Communication Station Inc.

We will use video to document baseline information during the initial evaluation process and to gather further information for a more in-depth view of your child's speech and language skills.

We also often use video and photographs to document progress throughout therapy. *No names will be mentioned with use of any pictures or video for marketing purposes*

I grant my permission to photograph/videotape my child during therapy sessions for use in further evaluation of my child and (**please check the applicable boxes**) :

□ documentation of my child's progress

□ education of parents and other professionals

□ for use in the brochure or marketing materials

□ for use on the website

□ for use on Austin's Communication Station's Facebook page.

We occasionally put these pictures up on the walls in the treatment area. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name only may be mentioned when referring to these pictures.

This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold Austin's Communication Station Inc. responsible for use of pictures or video already taken of my child.

Name of Child: _____Parent's Name: _____

Parent's Signature: _____ Date: _____

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Holiday Preferences and Clinic Schedule

Clinic Schedule

Austin's Communication Station Inc. will be closed on the following holidays: New Year's Eve, New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, Friday after Thanksgiving, Christmas Eve, Christmas Day.

In December, Austin's Communication Station Inc. will be closed for the week between Christmas and New Years. (from Christmas Eve until the first workday after New Years day).

In case of inclement weather, we will follow the school closings for Austin Independent School District. So, if you see that AISD is closed because of inclement weather, we will be closed as well.

Holiday Preferences

We at Austin's Communication Station Inc. enjoy celebrating some holidays by doing various art projects, reading books, playing with thematic toys, and possibly having small holiday celebrations. Our activities will always be about the secular (non-religious) aspects of the holiday. Please let us know if your family **does not celebrate** the secular aspects of any of these holidays below or if you would rather us **not** have your child participate in the holiday themed activities:

Please mark the blank if you do **NOT** wish for your child to participate in the holiday themed activities:

_____ MLK day/ President's Day

_____ St. Patrick's Day

_____ Independence Day

_____ Thanksgiving

_____ Valentines Day

_____ Easter

_____ Halloween

_____ Christmas

_____
Parent/Guardian Signature

_____
Date

AUSTIN'S
Communication Station

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Child Pick – up Permission

I hereby authorize the following people to pick – up or drop off my child when I am unavailable. Parents who wish to pick up their child should include themselves on the list below.

Guardian	Relationship	Phone Number
Guardian	Relationship	Phone Number
Guardian	Relationship	Phone Number
Guardian	Relationship	Phone Number
Guardian	Relationship	Phone Number

I authorize Austin's Communication Station Inc. to verbally share information regarding my child's session with those listed above for the purpose of continuity of care.

Child's Name	Date of Birth

Guardian Signature	Date

Austin's Communication Station Inc. Representative Signature	Date

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Consent and Acknowledgement

Consent for Care and Treatment:

As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as is necessary in her judgment. I understand that my child is under the care and supervision of my therapist. I authorize release of medical information to the Austin's Communication Station Inc. team for continuity of care.

_____ _____

Signature of legal representative of child Date

Acknowledgement of Notice of Privacy Practices:

I acknowledge that Austin's Communication Station Inc. will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. The Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

Your signature below indicates that you have received a copy of Austin's Communication Station Inc's Notice of Privacy Practices on the date you signed below. If you have any questions regarding the information in Austin's Communication Station Inc's Notice of Privacy Practices, please do not hesitate to contact Austin's Communication Station Inc's Patient Privacy Officer as indicated on your notice.

_____ _____

Signature of legal representative of child Date

Consent to Escort to the Restroom:

If the situation arises where the parent/legal guardian is not present on Austin's Communication Station, Inc. property during a session; I permit a therapist of Austin's Communication Station, Inc. to escort my child to the restroom if necessary during therapy sessions.

_____ _____

Signature of legal representative of child Date

Acknowledgement of Risk from Therapy Materials and toys:

I acknowledge that there is some risk inherent in the use of therapy equipment and toys at this clinic. I agree to indemnify and hold Austin's Communication Station Inc. harmless from any and all losses and claims for any injuries or other damage occurring to myself, my child, or our belongings from the use of therapeutic equipment.

_____ _____
Signature of legal representative of child Date

Acknowledgement of Risk from Therapy incentives and prizes:

I , _____, hereby release "Austin's Communication Station, Inc" from any and all liability resulting in any possible injury caused to the child who has been treated, their siblings, family members and/or pets, caused by toys and/or prizes given to my son/daughter, _____, as part of their patient incentives (prizes).

_____ _____
Signature of legal representative of child Date

Consent for communication via Email

Please check one blank:

_____ I DO consent for Austin's Communication Station Inc. to contact me by e-mail regarding my child's progress, scheduling, or billing issues.

_____ I DO NOT consent for Austin's Communication Station Inc. to contact me by e-mail regarding my child's progress, scheduling, or billing issues.

_____ _____
Signature of legal representative of child Date

Primary email address of parent/guardian if you consent to communication via email:

_____

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Patient Therapy Contract

Austin's Communication Station Inc. is dedicated to providing the highest quality of therapy services to all patients. The following policies and procedures have been designed and implemented in order to maximize progress toward the patient's therapeutic goals.

AS PARENT/GUARDIAN OF PATIENT, I AGREE THAT:

1. I will give at least a 12 hour notice (preferably 24 hour notice) if unable to make scheduled appointment. If my child's appointment is cancelled with less than 12 hours notice, I understand that I will be charged $25.00. If 12 hours is not possible, I will call to inform of cancellation prior to therapy session.

2. I understand that I will be charged a $50.00 fee for a no call/no show appointment.

3. I understand that after 2 consecutive "NO SHOWS", my child is subject to dismissal from therapy immediately.

4. I understand it is very important to be punctual with my appointment time. Consecutive tardiness can result in removal from the clinic schedule.

5. I understand my child's attendance to therapy must be consistent in order to maximize progress. I understand that only three absences will be allowed during a six month period (Jan 1-June 30; and July 1-Dec 31). After these three absences, a $25.00 charge per cancellation will be charged, even if I call prior to 12 hours before the appointment.

6. I understand my child cannot attend therapy services if he/she has an infection or contagious disease (example: fever, chicken pox, measles, thrush, impetigo, pink eye, strep, hepatitis, stomach virus, vomiting, diarrhea etc). *I understand they will be sent home if they show up sick to a therapy session.*

7. If there is a change in my phone number and/or address, or insurance; I will inform Austin's Communication Station of the change immediately.

8. I understand that for the safety of my child, an adult must remain in facility while my child is in session.

9. I understand that Austin's Communication Station Inc. will be closed on the holidays referred to in the Clinic Schedule form. I realize that these days do not count against my allowed number of absences for the attendance policy.

10. I realize that only people whom I have specified on the client pick up form are allowed to pick up my child from therapy sessions. Austin's Communication Station Inc. will not release my child to any other adults.

11. I understand that Austin's Communication Station Inc. will file insurance claims with some insurance carriers, but under most insurance plans Austin's Communication Station Inc. is an out-of-network speech therapy provider.

12. If payment is not issued by the insurance company within 60 days of initial filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals.

13. I understand that my child will be videotaped during their initial evaluation for baseline data purposes and more in depth evaluation of their speech-language skills. I also understand that if I give permission, my child might also be videotaped or photographed during other sessions in order to document progress, or for marketing purposes.

14. I acknowledge that Austin's Communication Station Inc. conducts speech therapy sessions (both individual and group) that will be observed at times by visiting professionals and University students to study our therapy techniques. Some sessions will be observed by these professionals or students and at times they may participate in treatment sessions. Confidential information about my child will not be shared with these professionals or students other than what is necessary to plan an effective lesson. At any time, our professional or student interacts with a client from our clinic, they will be accompanied by an Austin's Communication Station Inc. clinician. All lesson plans designed by a visiting professional or student will be implemented only after it's been approved by the lead Austin's Communication Station Inc. clinician.

15. I understand that Austin's Communication Station Inc. will only release information to people or organizations that have been specified by me or my authorized representatives.

16. I understand that my child will be escorted to the bathroom when necessary by an Austin's Communication Station, Inc. therapist if the parent/guardian is not on the property.

_____	_____	_____	_____
Parent/Guardian Signature	**Date**	**Witness Signature**	**Date**

Observation Confidentiality Agreement

Austin's Communication Station always welcomes parents, guardians and other authorized persons to observe treatment sessions. Although here at Austin's Communication we adhere to HIPPA rules and regulations, when parents/guardians observe speech or occupational therapy sessions in which their children are being treated, unintentional contact including: observing other children in the clinic, hearing information about the other children, or accidentally encountering information about other children visually or auditorily (by contact with the actual client; his/her family, or medical charts/records etc.) may occur.

In order to protect the privacy of all clients at Austin's Communication Station; observation requires a commitment of confidentiality to protect privacy.

WHILE OBSERVING, PLEASE ADHERE TO THE FOLLOWING POLICIES:

1. Do not share, copy, or collect any information from client records and personnel records all types of files, or other documents. Under no circumstances shall names, diagnosis, social security numbers or benefits information, including the identity of dependents, be released.
2. Do not distribute any information by telephone or any other source to persons outside of Austin's Communication Station or to persons within the clinic who do not have an official need for the information.
3. Keep the contents of discussions and conversations by Therapists concerning privileged, personal or confidential cases private.
4. Do not make copies or take notes about any of the above listed information or documents without consent from the Owner, without an appropriate request from the Clinic and official or a written release from the Owner of Austin's Communication Station, Inc.
5. Do not discuss diagnosis, disorders, goals or plans of care for children other than your own with clinicians or other people inside or outside of Austin's Communications Station.

The undersigned fully understands that an unintentional or intentional disclosure by them of client records or personally identifiable information to any unauthorized person could subject them to criminal and civil penalties under law.

Signature:_____Date:_____

Print Name:_____

www.ACSkids.com
7800 Shoal Creek Blvd, Suite 110W
Austin, TX 78757
Phone: 512-610-1190 Fax: (512) 610-1191
Email: info@ACSkids.com

Initial Evaluation Questionnaire

Patient's Name _____ Sex: M / F

Date of Birth: _____ Age: _____ Primary Phone#:_____

Address:_____City/Zip:_____

Mother: _____Home Phone: _____Mobile #: _____

Employer: _____Work Phone:_____
Address:_____City/ST/zip:_____

Father:_____HomePhone:_____Mobile #:_____

Employer: _____Work Phone:_____
Address:_____City/ST/zip:_____

Main contact email (s) for parents: _____

Are both parents listed above the biological parents? □Yes □No
If no, please explain: _____

Person Completing Form: _____ Relationship: _____

Patient lives with (circle): Mother&Father Mother Father Legal Guardian Other: _____
Name & Ages of Siblings: _____

IN CASE OF EMERGENCY:
Name of local friend or relative (not living at same address): _____

Relationship to child: _____ Main phone: _____ 2nd phone: _____

What languages are spoken in the home? What is the dominant language? _____
_____

Referred by:_____ Phone: _____

Address: _____

If referred by physician, reason for referral or ***Parental Concerns***:

Please list all physicians, professionals or specialists who follow your child and specialty:

1. Physician, professional, or specialist:

   Specialty:

2. Physician, professional, or specialist:

   Specialty:

3. Physician, professional, or specialist:

   Specialty:

4. Physician, professional, or specialist:

   Specialty:

5. Has your child ever seen a dentist?
   If so, **which dentist** and what did he/she have to say about your child's oral health/structure?

6. Any additional physicians or specialists and their area of expertise:

Prenatal and Birth History:

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Birth weight:_____ **Mother's age at child's birth:** _____

Pregnancy: □Normal □Difficult **Term**: □Full □Pre-mature (# of weeks) _____

Birth: □Caesarian □Vaginal **Length of Labor:** _____

Please circle all that apply to the child at or shortly after birth:

Twin Jaundiced Breech Forceps used Cord around neck

Was your child admitted to NICU (how long?) _____ Oxygen administered? Feeding tube?

Any other considerations at birth/pregnancy:

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History:

Describe current health:_____ height: _____weight: _____

Medical Diagnoses: _____

Please list all surgeries & dates since birth:_____
_____

Hospitalizations&Dates:_____

Major Ilnesses:_____

Current Medications:_____

Allergies: _____

History of Asthma? □Yes □No If yes, how is it currently controlled? _____

History of Ear Infections? □Yes □No If yes, were ear tubes placed? □Yes □No

If yes? When? _____

History of Seizures? □Yes □No

If yes, please provide details as to when and possible causes/triggers:
_____

Does your child have any assistive devices? □Yes □No

If yes please list:

Formal hearing evaluation?□Yes □No Where?_____Results:_____

Formal vision evaluation? □Yes □No Where?_____Results:_____

Developmental History

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Held head up							
Rolled over							
Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Ate finger foods							
Crawled							
Stood alone							
Walked by self							
Threw objects actively							
Ran by self							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Rode Tricycle							
Dressed self							
Rode bicycle without training wheels							
Caught a thrown object							
Demonstrated handedness (which?)							
Knew colors							
Counted to 5							
Knew alphabet							
Started reading							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							

Was your child breast or bottle fed?: _____

When was he/she weaned?: _____

Was there any difficulty weaning your child from the bottle/breast?

Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Stuttering/Stammering	
4			Drooling	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Breathing Thorough mouth	
11			Difficult transitions	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to touch (i.e. clothing)	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

Did/does your child suck his/her thumb or pacifier (now or prior): □Yes □No

If yes, which one: _____

If it was prior, when did he/she stop: _____

Describe your child's sleep habits:

Feeding/Chewing/Swallowing:

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, gagging)? If yes, please describe:

Describe your child's current eating habits/schedules:

Indicate any aversions/problems or preferences your child may have. Included are examples of each food group:

	Likes	Dislikes	Refuses	Difficulty Managing
Thin Liquids (ex. water)				
Thick Liquids (ex. milkshakes)				
Purees (ex. pudding)				
Textured puree (ex. applesauce, mashed potatoes)				
Mixed texture (ex. cereal with milk, or jello with fruit)				
soft solids (ex. banana, cheese, chicken nuggets)				
crunchy solid (ex. Goldfish, cracker)				
Hard to chew solid (ex. Raw carrots, steak, apples with peels)				
cold foods				
room temperature foods				
warm foods				

What are your child’s 3-5 favorite foods (put a star by the very favorite ones):

What kind of cup(s) does your child drink from (ex. bottles, sippy cups, straws, open cups):

Describe your child’s current diet (ex. Any prescribed diets, any extreme food preferences, any special diets followed by your family, or a basic description of your child’s diet):

Does your child like any unusual foods or combinations of foods?

Does your child have any food preferences based on color, shape, or flavor (sweet, salty, sour)? If yes, please explain:

Is there anything “different” or “unusual” about the way your child eats food (ex. doesn’t like to bite, small bites, stuffs mouth full, etc)?

Daily Life:

With whom does the child spend the most of his or her time?

Describe a typical day for your child:

Please circle all that describe your child's temperaments and activities:

easy going	regularly misbehaves	picky eater
difficult to calm	regularly fussy	does not get irritated
easily irritable	difficulty completing tasks	does not like to get dirty
easy to calm	difficulty attending to tasks	likes to be held often
indifferent	difficulty leaving parents	difficulty expressing needs/wants
difficulty with transitions	swings/ rocks him/herself regularly	
hyper focused on activities	difficulty understanding instructions	

Any comments on temperaments listed above??

Does your child have any self-stimulatory behaviors? If so, please describe:

Speech/Language:

Age your child:

Cooed: _____ Babbled: _____

Used single words (e.g., *no*, *mom*, *doggie*): _____

Combined words (e.g., *me go*, *daddy shoe*): _____

Named simple objects (e.g., *dog*, *car*, *tree*): _____

Used simple questions (e.g., *Where's doggie?*):_____

Engaged in a conversation:_____

Did your child ever gain language and then lose any language/words for a brief or extended period of time?

How does the child usually communicate his/her wants/needs? (gestures, single words, short phrases, sentences?)

Can you understand your child? yes no sometimes

What percentage of the time can you understand him/her? 80-100% 50% 50% or less

Can other family members/teachers understand his/her speech? yes no sometimes

Can strangers understand his/her speech? yes no sometimes

How often would you guess that strangers can understand him/her? 80-100% 50% 50% or less

What does your child do when he/she is not understood?

Family history – circle all that apply:

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER Or FATHER'S SIDE ?	WHO? (as related to your child)	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures (eg. Alzheimer's, Parkinson's)			
3			Respiratory disease or tuberculosis (eg. Asthma, COPD)			
4			Seizure Disorder			
5			Hormonal or Gland disorder (eg. Hypothyroidism, pituitary tumor)			
6			Delayed Motor Development (walking, crawling, etc)			
7			Allergies - food or environmental (specify which type and for whom)			

8			Hearing Loss			
9			Stomach disease/disorder/problems (eg. Reflux, Colitis, Chron's, Celiac)			
10			Senses problems - vision, hearing, touch, taste, smell, balance			
11			Swallowing or feeding problems (eg. described as picky eater as child, esophageal strictures)			
12			Attention/learning problems			
13			Hyperactivity/ADHD/ADD			
14			Autism Spectrum Disorder			
15			Developmental therapy (eg. Speech therapy, Physical therapy)			
16			Alcohol/drug use			
17			Psychological/nervous issues			

Have any of the child's siblings ever demonstrated delayed language skills, delayed physical or language milestones, academic difficulties, social difficulties or other disorders?

Describe your child's speech/language/feeding/sensory/motor problem in your own words:

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed? Please explain:

Do you think your child aware of the problem? If yes, how does he or she feel about it?

Has your Child ever been in therapy (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

Have any other specialists (physicians, audiologists, physical therapists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Educational/Social History

School/Day Care: _____ Grade/Class Type: _____
School Hours per day/week: _____

Previous schooling situations:

How is your child currently doing academically (or preacademically)?

Does the child receive special services at school (ex. speech therapy, occupational therapy, music therapy, adaptive PE etc? If yes, describe.

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals.

Describe your child's preschool experience? (how did they interact with peers there? How many years did they attend at the same school? How many different preschools did they attend? Were they ever asked to leave a preschool and if so why? Etc).

Does your child:

Make good eye contact with people?	Yes ___ No ___
Play with other children?	Yes ___ No ___
Get along well with other children?	Yes ___ No ___
Sit with the family for meal(s)?	Yes ___ No ___

Feel free to provide additional information about the above questions if you would like:

How does the child interact with other adults (e.g., friendly, outgoing, bossy, shy, aggressive, uncooperative)?

How does the child interact with other children (e.g., friendly, outgoing, bossy, leader, follower, shy, aggressive, uncooperative)?

Describe your child in a social situation, such as a family party or a play group:

- How does he/she act?

- What does he/she say?

- Where is he/she in relation to the other children at the play group/family function?

- Is he/she engaged/aloof/anxious etc in the social interaction?

Please list any items that your child enjoys or that are reinforcing for him/her: (ex. toys, foods, trains, social reinforcers like tickles etc)

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

What are your goals/expectations for therapy? What do you hope therapy will accomplish (long and/or short term goals):

Person completing form:_____

Relationship to client:_____

Signed:_____Date:_____