CASE HISTORY FORM

Identifying Information

Child's Full Name:____ Date:____________________
Person Completing Form:___________________________________ Referred By:_______________
Child's Date of Birth:______________ Age:________ Sex:________ Lives with:_________________
Home Address:____ Phone:___________________

Family History

Parent:
Mother's Name:________________ Age:________ Occupation:___________________________
Speech, language, or learning related problems:_____________________________________

Parent:
Father's Name:_________________ Age:________ Occupation:___________________________
Speech, language, or learning related problems:_____________________________________

Sibling Names:	Age:	Speech, language, or learning related problems:

Other people living in the home:____
Language spoken in the home (other than English):___________________________________

Birth History

Pregnancy: Normal:______ Problems:______ (If problems, please describe):________________
____
Medications taken during pregnancy:____
Other pregnancies: How many:_______ If problems, please describe:_____________________
Obstetrical: Hospital:____
Birth weight:_________ Labor: Normal_______ Induced_____ Length of labor________________
Special considerations: Caesarian_____ Premature_____ Breech_____ Child rotated____________

Medical History

Pediatrician:_____________________________________ Phone:_______________________
Address:____
Date of last physical exam:_____ Date of last hearing screening:______ Results:_________________

Tubes in ears:______________________ Date inserted:______________ Date removed:______________
Date of last vision screening:________________________ Does your child wear glasses?:______________
Allergies:______ Please describe:____
Current Medications (include name, dosage, and reason):______________________________________
____

Medical Background

(Check which applies to your child. State age and complications)

Frequent colds ____________________________ Infectious mono _____________________________
Frequent respiratory infections ______________ Endocrine disturbance __________________________
Frequent earaches or infections ______________ Spinal meningitis ______________________________
Hearing loss ______________________________ Heart trouble _________________________________
Chicken pox ______________________________ Epilepsy _____________________________________
Convulsions ______________________________ Cerebral palsy _________________________________
Operations _______________________________ Serious injuries _______________________________
Other illnesses ____________________________ Allergies ____________________________________
Hospitalization? When?______________ Where?____
Why?____

Motor Development

When did your child begin to…
Sit up:____________________________________ Crawl:____
Walk (at least 5 steps):______________________ Jump (with 2 feet):_____________________________
Go up stairs one foot after the other:____
Gain bladder control:_______________________________ Gain bowel control:______________________
Establish hand preference for eating:________________________ Which hand? ______________________
Establish hand preference for writing:_______________________ Which hand? ______________________
Establish hand preference for throwing:_____________________ Which hand? ______________________

Check any if appropriate: Trips easily ___ Clumsy with hands ___Climbs poorly ____ No fear____
Trouble with stairs _____ Afraid of climbing stairs ______ Runs into things ______

Please describe other motor concerns:____

Feeding Development

When did your child begin to…
Drink independently from a bottle:___________________ Drink from a cup by self:____________________
Eat table foods:_______________________________________ Use a spoon:______________________________
Do you have any concerns about: (If so, explain):
Biting:____ Chewing:__________________________________
Drinking:____ Swallowing:_______________________________
Does your child have any food allergies/preferences?____

Speech and Language Development

When did your child begin to:
Coo (primarily vowel sounds):________________ Babble (da-da-da):________________________________
Jargon (da-bee-boo) sounds like talking without words:____
Say his/her first word:______________________________ What was it:____________________________
Describe the circumstances:____
Combine words (e.g. "Mommy do," "want juice"):____
Was there ever a time when your child's speech and language skills regressed or he/she stopped talking?___________________________________ When?____________________________________
Please describe the circumstance:____
How intelligible (understandable) is your child's speech to the family?_________________________
____ To outsiders?___________________________
What concerns do *you have* about your child's speech and language?__________________________
____
How do these concerns interfere with the school setting?___________________________________
home environment?____
interpersonal relationships (social skills)? E.g. playing with other children_____________________
____
Have speech and language skills been evaluated before?____________________________________
If so, when?_______________________________________ Where?__________________________
Did the evaluation lead to any treatment?____
If yes, for how long?________________________________ By whom?________________________

Psychological and Neurological Development

Has the child had a psychological exam?______________ When?__________________________________
For what reason?____
Name, address and phone of Psychologist____
Has child has a neurological exam?__________________ When?__________________________________
For what reason?____
Name, address and phone of Neurologist____

Check any that apply to your child

________nervousness
________bedwetting
________excessive shyness
________easily upset
________temper tantrums
________rock or roll
________short attention span
________hyperactive
________nightmares
________restless
________destructive
________easily distracted

________sensitive to being touched
________tics
________sleeplessness
________sad
________aggressive
________withdrawn
________head banging
________hurts self
________fearful or new situations, strangers, or sitters

________staring at lights or objects
________persistent habits (nail biting, thumb sucking, nose picking)
________perseverates (doing things over and over)
________annoyed by loud sounds
________abnormal finger play

How are these concerns manifested at home?____

____

at school?____

Educational Development

Schools attended (including preschool): Grades: Dates:

____ _______________ ___________________________

____ _______________ ___________________________

____ _______________ ___________________________

Grades repeated:____

Current school placement:____

Specific concerns about current school program:____

____

Special services (e.g. tutoring) received at school:____

Who provides services?_____________________________ What subjects?_____________________________

How often?____

Special services received privately?____

Who provides services?_____________________________ What subjects?_____________________________

How often?____

What information are you hoping to obtain as a results of this evaluation?________________________

____

____

Information Release Form

Childs Name:____

I hereby give permission to Communication Connections, LLC to discuss, release or obtain information relative to my child's therapy from the following professionals:

Name	Title	Phone and/or email

_______________________________________ _______________________________________

Parents /Guardian Signature Relationship to Child

Policies and Procedures

July 18, 2017

Communication Connects, LLC is pleased to have you as a valued family in this practice. This practice offers a full-range of Speech-Language Therapy Services as well as collaboration with any support services you might need for your child.

In order to keep these services operating at an optimal level, as of September 15, 2017 the Policies and Procedures are:

1. The attached Fee Schedule details billing amounts for comprehensive speech-language evaluations and individual and group therapy sessions both in the Communication Connects office and outside of the office.

2. An invoice will be issued at the last session of each month via email or in person if requested. Payment in full is to be made at that time by cash or check (Credit Card payment coming soon!). Please make a prompt payment when you receive your invoice to avoid any late fees. Some medical insurance policies will cover our services. You will need to submit a copy of the itemized invoice to your insurance carrier. **Regardless of the status of these insurance claims, payment in full to Communication Connects, LLC is expected upon receipt of the invoice at the end of the month**. If the insurance company should issue a check to Communication Connects, LLC it will be promptly endorsed and sent directly to you. Communication Connects, LLC reserves the right to discontinue therapy services if payment is not received according to our payment policy. Therapy can also be discontinued if there is any violation of the Communication Connects, LLC policies and procedures.

3. There is a 24-hour cancellation policy. If less notice is given, regardless of the unexpected circumstance, the full hourly fee will be charged. Please remember that once a therapy schedule has been set, that time is reserved for your child. Our therapists are paid hourly for their time. If they do not have enough time to reschedule a cancelled session they do not get paid for this time. **Therefore, a cancellation made less than 24 hours in advance is billed at the full hourly fee**. If you need to cancel, please do so in advance either in person or contact your speech-language pathologist directly by leaving a message on the voicemail system or email with 24 hours notice of your appointment time. We are attempting to be as clear as possible with this policy so that any situation that may arise will not intrude on the therapeutic relationship we share.

4. Our sick policy is designed to ensure your child's health and your therapist's health-keeping those around us as well as possible that we can all do our job. It is NOT beneficial for your child to participate in therapy while they are ill or contagious. For these purposes your child must be fever-free and vomit-free for 24 hours. If your child has a contagious illness (such a strep throat, pink eye, green discharge from nose/eyes, chicken pox, lice, etc.) your child should be under the treatment of a physician when necessary and be receiving appropriate care for at least 24 hours prior to the session. Again all cancellations made less than 24 hours in advance are billed at the full hourly fee since your therapist reserved this time for your child. If your child has had an illness for 4-7 days and is no longer contagious but has residual side effects such as runny nose or cough, please use your best judgment. So that we do not spread any illnesses, the practice we will provide hand sanitizer; we also encourage that you help your child with hand washing prior to the sessions. If your therapist happens to be ill; they will notify you as soon as possible and will try to reschedule thatsession.

5. If there is a concern about weather, you must contact your therapist directly in the morning to discuss these conditions. Communication Connects, LLC does not follow Hillsborough County Public School closings.

Name: ____

I have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health information.

______________________________ ______________________

Parent/Guardian Signature Date

____

Printed Name of Parent/Guardian

I understand the Communication Connects, LLC cancellation and payment policy. I understand that a cancellation made less than 24 hours in advance is billed at the full hourly fee. I also understand that payment for therapy services is due immediately upon receipt of the monthly invoice.

______________________________ ______________________

Parent/Guardian Signature Date

____

Printed Name of Parent/Guardian

Fee Schedule for Communication Connects, LLC

Individual Speech-Language Therapy Sessions

Sessions at Communication Connects office with 1 therapist and 1 child

$95.00 per hour

Sessions outside of the office will be billed at the hourly fee specified below. Additional charges for travel time to and from the site will be billed at the same hourly fee.

0-30 minutes: $47.00

30-60 minutes: $95.00

Group Speech-Language Therapy Sessions

Sessions at the Communication Connects office with 1 therapist and 2 or more children

$70 per child in the group

Evaluations and Written Reports:

$95.00 per hour

This fee is for the actual time the child is being evaluated. Additional billing, at the standard hourly office rate, will be added for the preparation of a written report if request by the parents (not to exceed 2 additional hours).