JOHN MUIR HEALTH

PEDIATRIC SPEECH, LANGUAGE AND HEARING HISTORY

IDENTIFICATION:

Child's Name________________________________ Age_______ Sex_______ Birth date_________

Address____ Phone______________________

City____ Zip Code __________________

FAMILY HISTORY:

Father____

Mother____

Marital Status of Parents_____________________

Brothers and Sisters: Name Age

___________________________________ ____________

___________________________________ ____________

___________________________________ ____________

Other persons living in the home____

Please describe, in your own words, the child's speech language, voice or reading problem.

____

____

What do you believe may have caused the problem?____

____

Who first noticed the problem and when?____

____

PREGNANCY, BIRTH AND DEVELOMENTAL HISTORY:

Were there any complications and illnesses during this pregnancy? _____________________________

____

Was delivery normal? _______ If not, please explain:____

____

To the best of your knowledge, at what ages did the following first occur?

Held head up __________ Walked alone ____________ Put words together____________
Sat up __________ Began to babble __________ Dressed Self _____________
Crawled __________ Imitated sounds ___________ Tied shoes _____________
Stood alone ___________ Said first word ___________

Which hand does the child prefer to use? Right Left

MEDICAL HISTORY:
Please circle those diseases child has had and indicate age and duration:

	Age	Duration		Age	Duration
1. Measles	_______	___________	6. Pneumonia	______	___________
2. Whooping Cough	_______	___________	7. Ear Aches	______	___________
3. Scarlet Fever	_______	___________	8. Convulsions	______	___________
4. Chicken Pox	_______	___________	9. Allergies	______	___________
5. Mumps	_______	___________	10. Other______	______	___________

List and describe any accidents, injuries, operations or hospitalizations:
____

____

List any current medical treatments or medications:_______________________________________

____

Does your child have any of the following?

Visual defect ___________ Emotional problems __________________
Hearing defect ___________ Behavior problems __________________
Hearing aid ___________ Defect of tongue, jaw,
Cleft Palate ___________ teeth or lips ___________________
Other physical defects______________________________

Child's Physician__________________________________ Phone#__________________
Address __________________________________

Other Physicians:

Name	Specialty	Address	Date
_______________	________________	___________________	__________
_______________	_________________	____________________	___________

Other Clinics or Professionals who have examined the child (such as psychologists, speech pathologists, etc.):

Name	Specialty	Address	Date
______________	____________________	________________	___________
_______________	_____________________	_________________	___________

SOCIAL:

What kinds of play does your child enjoy most?____

____

How does your child get along with friends? ____

____

How does your child get along with family members? ____

____

Does your child prefer to play alone? __________ Does your child play alone as well as play with other children?____

How would you describe your child's disposition? What are the main personality traits? __________

____

What kind of activities are engaged in by the entire family? ____________________________________

____

Is your child in a school or pre-school setting? ______________________ If so, please describe:______
____

How does your child get along there? ____

How does your child react to discipline? ____

SPEECH AND LANGUAGE:

How does your child usually communicate with you (speech-gestures, etc.)?

____

Is the child's speech generally understood by: Family ____
Other children___________________________ Other Adults_____________________________________

Does your child usually understand what you say to him/her? _________________________________

If not, how do you communicate with him/her? ____

____

Have you tried to help your child's speech? ____

____

If your child has had speech therapy, indicate when, by whom, for how long and whether, in your opinion it was beneficial.

____

____

____

GENERAL:

What language(s) are used in the home? ____

Do any other immediate family members have a history of speech or language problems? If so, describe: ____

____

____

Have any other immediate family members ever had unusual illnesses, emotional problems or learning disabilities? If so describe: ____

____

____

Has your child's hearing been tested? Y N If yes, what was the outcome? ___________________

____

Please give any additional information you believe may bear on your child's problem:

____

____

____

____

Date_______________

Report filled out by ____

Relationship to child____

Case History for Children With Feeding Problems

Complete this form if your child is 6+ months and beginning to eat / already eating solids

Name ________________________________ DOB ____________________ Age ____________

Primary caregiver(s) ____

Address____

Phone (home) _____________________ (cell) _____________________ (other) ___________________

Primary care physician ____

Other physicians who see the child ____

Why is your child being seen for a feeding evaluation?

____

____

When did these problems begin? ____

Please list anyone else who has evaluated your child for this feeding problem.

____

____

Prenatal and Perinatal Medical History

Weight of your child at birth __________ Was your child full term? __________

If premature, how many weeks gestation? _____________

How long was your child hospitalized after birth? ______________________

Describe any problems during pregnancy.

____

____

Describe any problems during or immediately after birth.

____

____

Postnatal Medical History

Does your child have any medical diagnoses? If yes, please list.

____

____

Describe any family history of similar problems. ____

____

If your child has ever been hospitalized, list dates and reasons.

____

Describe any special medical tests.

____

Describe any dental problems
____
If your child has had any surgeries, list dates and reasons.
____
____

Describe any respiratory problems (e.g., pneumonia, bronchitis, asthma, noisy breathing).
____
____

Describe any gastrointestinal problems (e.g., vomiting, diarrhea, constipation, gas).
____
____

List any medications your child takes and the reason for the medicine.
____
____

Describe any allergies.
____
____

Sleep Patterns

When does your child go to bed at night? ___________
How many hours does he or she sleep? _____________
Does your child nap during the day? _________ If yes, when and how long does your child sleep?
____

Does your child sleep through the night? __________ Does your child snore? __________
Is your child a mouth-breather when asleep? __________

Food and Nutrition

Feeding Milestones

Was your child breast-fed? _______ If yes, for how long? _______
Does your child still breast-feed? ____
Did your child have any trouble with breast-feeding (e.g., poor suck, slow to feed, poor latch)?
____
____
____

When was your child's first bottle? ___________ Did your child have any trouble with the bottle? _____
If yes, please describe.
____

At what age did your child try cereal?_________
Describe any problems encountered with spoon feeding cereal and other solids?____

When was your child weaned from the breast or bottle to cup drinking?___________
Describe any problems with moving to cup drinking
____
____

At what age did your child begin to eat foods that require biting/chewing?________________
Describe any problems with biting/chewing____

Current Information
What is your child's current weight? __________ height? __________
Where does your child fall on the growth charts? ______ percentile weight ______ percentile height

How would you describe your child's appetite? Good fair poor varies
Please explain.
____
____

Which of the following does your child drink? ¨ cow's milk ¨ soy milk ¨ breast milk ¨ formula- type of formula: ________________________

If your child is nursing, does mother have adequate production of milk? __________

How much of the following does your child eat and drink in a typical 24-hour period?
food __________ liquid __________ supplements _____________

How many times a day does your child eat? ______________
How long is it between meals? _________________________
How long does each meal take? ____

Does your child use any special equipment to eat? ¨ bottle ¨ nipple ¨ cup ¨ spoon
If yes, please describe. ____

What is your child's position when eating/being fed? held by caregiver ¨ in high chair ¨ in seating device
(describe position ____)

Does your child eat more/less/same amount in the following situations?
with other relatives ______________________ with other adults (e.g., babysitter) ___________________
at school/daycare ________________________ with others ________________________
Does your child receive any supplemental feeding? ___________________
If yes, please circle: NG PEG PEJ oral supplements

Who usually feeds your child or do they self-feed?
____
Which, if any, of these behaviors does your child exhibit during a meal? ¨ crying ¨ spitting out food
¨ holding food in mouth ¨ gagging ¨ vomiting ¨ refusing to eat ¨ turning head away ¨ clamping mouth shut
When this happens, what do you do?
____

What does a typical meal look like : (include what your child eats/drinks and how much of each, do you have to thicken the liquids?)
Breakfast
____

Lunch

Dinner

Snack

What temperature foods and liquids does your child prefer: Room temperature Warm Cold

What foods are easy for your child to eat:____
What foods are difficult:____

Where does your child typically eat at home?

______________________________________ ________________
Person Completing Form Date

Case History for Infants/Children With Feeding Problems
Complete this form if your child is 0-12 months and not yet eating solids

Name ___________________________________ DOB _____________________ Age _____________
Primary caregiver(s) ____

Address____

Phone (home) ______________________ (cell) ______________________ (other) ____________________

Primary care physician ____

Other physicians who see the child ____

Why is your child being seen for a feeding evaluation?
____
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When did these problems begin? ____

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If your child has had any surgeries, list dates and reasons.

____

____

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____

____

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____

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____

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____

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____

____

____

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If yes, please describe.

____

____

____

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¨ holding food in mouth ¨ gagging ¨ vomiting ¨ refusing to eat ¨ turning head away ¨ clamping mouth shut
When this happens, what do you do? ____
____
____
____

_______________________________________ ________________
Person Completing Form Date

Adapted from: The Source for Pediatric Dysphagia Second Edition Copyright © 1998, 2010 LinguiSystems, Inc.

Cancellation/No Show/Co-Pay Policies

Thank you for choosing John Muir Health for your therapy services. Due to the volume of new patients and limited appointments, we require that you notify our office **24 hours in advance** if you are unable to keep your appointment. We do understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a “No Show.” **After two such occurrences, any additional scheduled appointments will automatically be cancelled.** Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than ten minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system’s billing department.

We want to meet the goals of all of our patients and appreciate your assistance. Thank you for your help! Please let us know if there is something more we can do for you.

To cancel or reschedule appointments, please call (925) 947-5300.

Sid Hsu, Director
Rehabilitation Services
John Muir Health

I acknowledge that I have read and understand these policies.

______________________________ ____________________

Patient Signature Date

SCHEDULING COMMUNICATION PREFERENCE

Please Print

PATIENT NAME: ________________________________ **DATE OF BIRTH:** ______________

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding scheduling issues.

- ❑ No, it is not ok to leave messages or voicemails.
- ❑ Yes, it is ok to leave messages or voicemails.

Please write all of YOUR contact numbers where we may leave a message:

Home Phone:	Work Phone:	Cell Phone:
(______)____________________	(______)____________________	(______)____________________

Persons authorized to receive messages/information at above numbers

______________________	______________	______________________	______________
Name	Relationship	Name	Relationship

Only the above people will be able to confirm or change your appointment.

Please note: ANY PERSON (including family members) requesting **ANY** information, including appointment confirmations and changes, MUST provide us with 3 points of information about you including: 1. Name, 2. Date of Birth, 3. Zip Code.

Thank you for assisting us.

I authorize John Muir Therapy Center to leave protected health information inquiries that may include the following: Name of patient; Name and phone number of our clinic; Name of treating Therapist(s) or Doctor; Name of referring Doctor; Appointment times and dates; and Scheduling information/requests.

Signature: ________________________________ Date: _____________________

Relationship, if not patient: _________________________________

1. **Preferred language for discussing healthcare with your provider:** _________________
2. **Do you consider yourself of Hispanic or Latino Ethnicity?** **Yes** **No**
3. **Which category best describes your race? Circle One**

   Asian Black/African-American/African Pacific Islander or Native Hawaiian

   Caucasian Native American/American Indian/Eskimo Multi-racial/Bi-racial Other

CONDITIONS OF REGISTRATION

Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or Facility services rendered the patient under the general and special instructions of the patient's physician or surgeon.

Personal Valuables: The Facility shall not be liable for loss or damage to personal property.

Trainees: The Facility conducts training programs for health care professionals. These persons may be observing or participating in the Facility's treatment program. They will be under the direct supervision of licensed professionals. The undersigned has a right to refuse to have trainees participate, at any time, in his/her care.

Consent to Photography: The undersigned consents to photography (still images, videotaping, filming, etc.) for purposes related to diagnosis and treatment or for use in training or education programs.

Release of Information upon Public Inquiry: Requests for patient information must contain the patient's name. The Facility may then, unless otherwise requested by the patient, legal representative, or provider of health care, release at its discretion the patient's condition described in general terms (that do not communicate specific medical information) and the patient's location within the hospital. The Facility will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the Facility is permitted or required by law to release information. No information will be released to the public with regards to psychiatric and/or chemical dependency treatment.

Release of Information for Payment: To the extent necessary to obtain payment, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including, but not limited to, insurance companies, Health Care Service Plans, workers' compensation carriers, social security administration and peer review organizations. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Health Care Service Plans: It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

The undersigned acknowledges he/she has read and understands the Conditions of Registration and has received a copy thereof. Furthermore, the undersigned is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.

_______________ PRINT NAME: PATIENT, LEGAL REPRESENTATIVE, AGENT

_______________ SIGNATURE

_______________ DATE OF BIRTH

_______________ DATE/TIME

_______________ RELATIONSHIP IF NOT PATIENT

_______________ WITNESS

☐ Unable to sign

Acknowledgement of the Notice of Privacy Practice

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices.

_______________ DATE

_______________ TIME

_______________ SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT

Dear Parent/Guardian:

Thank you for choosing John Muir Health for your therapy services.

We strive to provide the best care to each patient and appreciate your assistance.

We ask that you remain on the premises to allow for discussion of your child's care/treatment or should there be any type of emergency.

We understand siblings may need to accompany you to your child's appointment(s). In such circumstances please monitor the safety of all siblings while on the premises and for safety reasons please do not allow them to use any therapeutic equipment or toys.

Thank you,

Sid Hsu, Director
John Muir Health
Rehabilitation Services

I acknowledge and understand the need to be present during my child's appointment. John Muir Health will not be held liable for my child's welfare in the absence of a parent/guardian and may contact emergency services as necessary to safeguard my child. I accept responsibility for monitoring the behavior and safety of siblings that may attend therapy sessions. John Muir Health will not be held liable for any injury a sibling may incur due to lack of parental supervision.

Parent/Guardian Print Name: ______________________________

Signature: ___________________________ Date: ______________

Relation to patient: ____

Food Preferences and Refusals

Child's Name: **Completed By:** **Date:**

Please list foods and drinks your child likes and dislikes. If you prepare any of these foods in a certain way in order for your child to eat it, please describe.
(Ex. If you have to cut sandwiches in a certain shape, or apples only peeled and cut into chunks, macaroni & cheese if only certain brand)

Drinks	
Likes	Dislikes

Breakfast Foods	
Likes	Dislikes

Breads	
Likes	Dislikes

Vegetables	
Likes	Dislikes

Fruits	
Likes	Dislikes

Meats	
Likes	Dislikes

Snacks	
Likes	Dislikes