SpeechBuilders, LLC
Speech and Language Therapy
150 East 1st Street, Apopka, FL 32703
Office: 407.970.8484 Fax: 407.910.2923
www.speechbuilders.org

Patient Information

Patient______________________ DOB_________________ Age___________

Parents____

Address_________________________ City_______ State/Zip______________

Phone: (home)________________________ (cell) _______________________

School________________________ Phone_____________________________

Insurance______________________ Member ID________________________

Insurance Phone Number ____

Doctor ____________________________ Phone _________________________

Reason for Evaluation ____

AUTHORIZATION

I authorize Adrienne Fuller M.S., CCC-SLP/ SpeechBuilders, LLC to evaluate my child, _______________________. I understand that I will be responsible for the payment at the time of service. CANCELLATIONS MUST BE CONFIRMED WITH YOU CLINICIAN 4 HOURS IN ADVANCE. I authorize communication between coordination of payment. I authorize verbal and written communication between SpeechBuilders, LLC and my child's doctor 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.

_________________________________ _________________________________

Printed Name of Parent Parent's Signature

____

Date

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Case History Form

Patient's Name____

DOB____

Language (s) spoken in Home____

Language (s) Spoken by Caregiver_______________________________________

Background Information

Describe your primary concerns regarding your child?

____

At what age did you first become concerned?

____

Are there any other family members with a history of developmental concerns (e.g. mental deficits, learning deficits, cerebral palsy?

____

Child lives with (circle one):

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

Parent and Step Parent Other_____________________________________

Prenatal/Birth History

History of pregnancy (medication, health of mother, complications)

____

Number of children ________________

Names and ages of children ____

Was Pregnancy full term of premature? (If premature how many weeks?)

____

Type of Delivery: Vaginal ___________ C-Section ____________ Breech ____________

Note complications of labor/delivery including medications

____

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Birth Weight ________________________

Did/Does your child have difficulty?

Sucking_____ Swallowing______ Chewing _____ Changing to Solids_________

List any medications currently being taken

____

Developmental History

Developmental Milestones (give approximate age):

Sat Alone________ Crawling________ Walking________ Running_______ Holds Bottle______

Babbling____________ First Words_________ Sentences________ Dressing Self________

Current Speech-Language-Hearing

Does your child:			**Your child currently communicates using**:		
Repeat sounds, words or phrases over and over?	Yes	No	Body Language	Yes	No
Understand what you are saying?	Yes	No	Sounds (vowels, grunting)	Yes	No
Retrieve/point to common objects upon request (ball, cup shoe)?	Yes	No	Words (shoe, doggy, up)	Yes	No
Follow simple directions (“Shut the door” or “Get your shoes”)?	Yes	No	2 to 4 words sentences	Yes	No
Respond correctly to yes/no questions?	Yes	No	Sentences longer than four words	Yes	No
Respond correctly to who/what/where/when/why questions?	Yes	No	Other:		
Behavioral Characteristics:					
Cooperative	Yes	No	Stubborn	Yes	No
Attentive	Yes	No	Restless	Yes	No
Willing to try new activities	Yes	No	Easily distracted/ Short attention	Yes	No
Plays alone for reasonable length of time	Yes	No	Destructive/Aggressive	Yes	No
Separation difficulties	Yes	No	Inappropriate behavior	Yes	No
Easily frustrated/impulsive	Yes	No	Self-abusive behavior	Yes	No

Academic Concerns: ____

Behavioral Concerns: ____

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Acknowledgment That You Have Received Our HIPPA Privacy Notice/Policies/Procedures

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

- ✓ Notes from your doctor, teacher, or other health care providers
- ✓ 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 tells you how your health information may be used and shared. It almost tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice and patient rights.

___________________________________ ___________________________________

Print Patient's Name Date

___________________________________ ___________________________________

Patient or Parent/Guardian Signature Relationship to Patient