



## Child Case History Form

**DEMOGRAPHIC AND FAMILY INFORMATION:**

**Child's Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_  Male  Female

**Home Address:** \_\_\_\_\_

**Home phone number:** \_\_\_\_\_

**Parent/guardian's Name:** \_\_\_\_\_ **Daytime phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

\_\_\_\_\_ **E-mail:** \_\_\_\_\_

\_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Parent/guardian's Name:** \_\_\_\_\_ **Daytime phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

\_\_\_\_\_ **E-Mail:** \_\_\_\_\_

\_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Doctor's phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Child accompanied to evaluation by:** \_\_\_\_\_

**Others living with child:**

Name	Relationship to child	Age	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Child's race/ethnic group:**

- Caucasian, Non-Hispanic
- Hispanic
- African American
- Native American
- Asian or Pacific Islander
- Other: \_\_\_\_\_

**Is there a language other than English spoken in the home?**  Yes  No

If yes, which one? \_\_\_\_\_

Does the child speak the language?  Yes  No

Does the child understand the language?  Yes  No

Who speaks the language? \_\_\_\_\_

Which language does the child prefer to speak at home? \_\_\_\_\_

**OCCUPATIONAL THERAPY**

Do you believe your child has motor delays?      \_\_\_ Yes      \_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you believe your child has sensory issues or sensitivities?      \_\_\_ Yes      \_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you believe your child has behavior concerns?      \_\_\_ Yes      \_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever had an occupational therapy evaluation/screening?      \_\_\_ Yes      \_\_\_ No

If yes, where and when? \_\_\_\_\_  
What were the results? \_\_\_\_\_  
Did he/she receive OT Services? What treatment intervention did they receive? \_\_\_\_\_  
\_\_\_\_\_

Has your child ever received speech therapy?      \_\_\_ Yes      \_\_\_ No

If yes, where and when? \_\_\_\_\_  
What was he/she working on? \_\_\_\_\_  
\_\_\_\_\_

Has your child received any other therapy evaluation? (physical therapy, speech therapy, counseling, etc.)

\_\_\_ Yes      \_\_\_ No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is your child aware of, or frustrated by, any motor or sensory difficulties?

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

What do you see as your child's most difficult problem at home? \_\_\_\_\_  
\_\_\_\_\_

What do you see as your child's most difficult problem in school? \_\_\_\_\_  
\_\_\_\_\_

What are some of your child's strengths? \_\_\_\_\_  
\_\_\_\_\_

**BIRTH HISTORY**

Were there any difficulties with the pregnancy or birth?  Yes  No  
If yes, please describe: \_\_\_\_\_  
How many weeks was the pregnancy? \_\_\_\_\_  
Did the child require a stay in the hospital after birth?  Yes  No  
If the child stayed at the hospital, please describe why and how long. \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Has your child had any of the following?  
 adenoidectomy  encephalitis  seizures  
 allergies  flu  sinusitis  
 breathing difficulties  head injury  sleeping difficulties  
 chicken pox  high fevers  tonsillectomy  
 colds  measles  tonsillitis  
 ear infections  meningitis  vision problems  
how often? \_\_\_\_\_  
 ear tubes  scarlet fever  
 Other serious injury/surgery: \_\_\_\_\_

Does your child have any medically diagnosed illness or conditions not listed above?  Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently (or recently) under a physician’s care?  Yes  No  
If yes, why? \_\_\_\_\_  
\_\_\_\_\_

Please list any medications your child takes regularly: \_\_\_\_\_  
\_\_\_\_\_

Is your child up to date on childhood vaccinations? \_\_\_\_\_

Does your child have any allergies to foods/medicines? \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Please tell the approximate age your child achieved the following developmental milestones: (NOTE: If you can’t remember the age, you can write “same” as peers, “earlier” than peers, or “later” than peers.)

Motor:

\_\_\_\_\_ sat alone  
\_\_\_\_\_ crawled  
\_\_\_\_\_ rolled over  
\_\_\_\_\_ stood unassisted  
\_\_\_\_\_ walked  
\_\_\_\_\_ toilet trained

Speech/Language:

\_\_\_\_\_ babbled  
\_\_\_\_\_ said first words  
\_\_\_\_\_ put two words together  
\_\_\_\_\_ spoke in short sentences  
\_\_\_\_\_ understood simple directions

Are there or have there ever been any feeding problems (for example, problems with sucking, swallowing, drooling, chewing, etc.)?  Yes  No

If yes, please explain: \_\_\_\_\_

**CURRENT DEVELOPMENTAL SKILLS**

Does your child...

- Reach for toys
- Hold toys
- Make eye contact
- Drop toys when they want to hold them
- Have difficulty dropping/releasing toys when they want to do that
- Pick up small objects (ex: Cheerios)
- Bring items (toys, finger foods) to their mouth
- Frequently reach for items/toys and miss
- Bring everything to their mouth
- Over or under react to loud noises
- Avoid or seem uncomfortable with messy hands/face

How does your child participate in daily living skills:

- Age appropriate (bathing, washing hands, eating, drinking, tooth care, dressing, managing school work)
- Dependent in all self care
- Participates/cooperates (ex: will rise arm to help put on coat or shirt) but not age appropriate
- Some age appropriate independence but requires assistance with 50% or more
- Near independent but requires occasional assistance

**BEHAVIOR/PLAY/SOCIAL INTERACTION**

Please describe your child:

- |  |  |
|--|--|
| <input type="checkbox"/> cooperative   | <input type="checkbox"/> easily distracted/short attention |
| <input type="checkbox"/> attentive   | <input type="checkbox"/> destructive/aggressive            |
| <input type="checkbox"/> willing to try new activities   | <input type="checkbox"/> withdrawn                         |
| <input type="checkbox"/> Easily frustrated   | <input type="checkbox"/> plays well with peers             |
| <input type="checkbox"/> Poor eye contact  | <input type="checkbox"/> prefers to play alone             |
| <input type="checkbox"/> Plays well with siblings  | <input type="checkbox"/> Plays well with caregivers        |
| <input type="checkbox"/> Prefers play with strict rules (not imaginary play); reality based play |  |
| <input type="checkbox"/> Prefers imaginary play; likes to make up stories when playing           |  |

Do you have any concerns about your child's behavior? If so, please describe:

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What does your child like to play with most? \_\_\_\_\_

How much screen time does your child get:

Each day? \_\_\_\_\_

Each week? \_\_\_\_\_

**SCHOOL HISTORY**

If your child is in school (or preschool), please answer the following:

Name of school and grade in school: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Has your child repeated a grade? If yes, which one(s): \_\_\_\_\_

What are your child's strengths and/or best subjects? \_\_\_\_\_

Is your child having difficulty with any subjects? \_\_\_\_\_

Is your child receiving any help in school (for example, special education services, tutoring, etc.)?

If yes, please describe:

\_\_\_\_\_

**ADDITIONAL COMMENTS**



# Speech Works of Alabama, LLC

## CONSENT TO TREAT- CHILD

I, \_\_\_\_\_ the parent/legal guardian of \_\_\_\_\_, hereby request and consent to Speech Works of Alabama, LLC to perform evaluation, treatment and care for my child as prescribed by a physician and/or recommended by a occupational therapist.

I understand and am informed that, as in the practice of medicine, occupational therapy and feeding therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment.

I acknowledge and agree that a parent or legal guardian must be present during each treatment session (note: parent or legal guardian may provide written consent in person for another adult to accompany child to speech therapy, for example, a grandparent).

I have carefully read and fully understand this Consent to Treat form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Speech Works of Alabama, LLC to administer evaluation and treatment under the direction of a certified occupational therapist, or treatment under a COTA.

**Signature of Parent/Legal Guardian:** \_\_\_\_\_

**Printed name of Parent/Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_



# Speech Works of Alabama, LLC

## Patient Waiver/Consent and Agreement to Pay Form

I, \_\_\_\_\_ understand that by signing this waiver, I am agreeing to pay for any non-covered services provided by Speech Works of Alabama, LLC.

Every billing effort will be made to obtain reimbursement of the services provided from my insurance carrier. In the event of a denial of payment by the insurance carrier, I agree to be responsible for the allowed amount of the charges or a remaining balance after my insurance has paid in full. I understand that as a patient/guardian, I have the responsibility to notify Speech Works of Alabama, LLC in the case that my insurance coverage changes.

I have read and understand the terms of this form.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

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#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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## Your Rights *continued*

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.

**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Example:** We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

**Example:** We give information about you to your health insurance plan so it will pay for your services.

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**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

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**Do research**

- We can use or share your information for health research.

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**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

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**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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**Address workers’ compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

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**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**



**Speech Works**  
of Alabama, LLC

### Notice of Privacy Practices

My signature below acknowledges that I have received a copy of Speech Works of Alabama, LLC's Privacy Practices, and affirms that I understand its contents. I understand that I have the right to ask for additional copies at any time.

Patient's (or guardian's) signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Speech Works of Alabama, LLC

1400 Hwy 78 W., Ste 200  
Jasper, AL 35501  
P: (205) 512-1117  
F: (205) 512-1113

## ATTENDANCE POLICY

Regular attendance is vital to ensure the best possible therapy outcomes. Our attendance policy is as follows:

- 3 “no-shows” may result in discharge.
- Excessive cancellations may result in discharge.
- Excessive late arrivals may result in discharge.

If you/your child is discharged, you will receive a phone call and/or letter.

We know that things happen, and will be more than willing to try to work with your family with any scheduling needs. If conflicts with your therapy time develop, please allow us to adjust your time/day if possible.

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Signature

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Date

**Speech Works of Alabama, LLC  
1400 Highway 78 West, Ste 200  
Jasper, AL 35501**

## **NONDISCRIMINATION POLICY**

As a recipient of federal financial assistance, Speech Works of Alabama, LLC does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Speech Works of Alabama, LLC directly or through a contractor or any other entity with whom Speech Works of Alabama, LLC arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Speech Works of Alabama, LLC  
Emily Sentell  
205-512-1117

**Speech Works of Alabama, LLC**  
**1400 Highway 78 West, Ste 200**  
**Jasper, AL 35501**

## **SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY**

The regulation implementing Section 504 requires that an agency/provider *"shall adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons."* (45 C.F.R. §84.22(f))

This provider and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level. Building is single-level.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, and patient treatment areas.
- A full range of assistive and communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids:
  - Readers for persons with visual impairment
  - Interpretation services (Boostlingo) for patients who communicate via ASL.
  - Writing materials/computers/tablets for persons with speech impairments.
  - Assistance with writing as needed.
  - Etc.

**If you require any of the aids listed above, please let the receptionist or speech therapist know.**