Julia Hobbs Speech Pathology, Inc.

CHILD'S NAME: _____ Date of Birth: _____ Sex: _____

Home Address: _____ Home Phone#: _____

City _____ State: _____ Zip Code: _____

MOTHER'S NAME: _____ SS# _____ Age _____

Home Address: _____ Driver's License# _____

City _____ State: _____ Zip Code: _____

Home Phone#: _____ Mobile Phone#: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Business Phone#: _____

FATHER'S NAME: _____ SS# _____ Age _____

Home Address: _____ Driver's License# _____

City _____ State: _____ Zip Code: _____

Home Phone#: _____ Mobile Phone#: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Business Phone#: _____

Reason for Referral: _____

Speech Pathology services are provided for the patient with the understanding that payment for such services is solely the responsibility of the patient, parent, or guardian. Julia Hobbs Speech Pathology, Inc. will cooperate in assisting the patient to secure insurance reimbursement for speech therapy services. By doing so Julia Hobbs Speech Pathology, Inc. makes no expressed or implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you. PAYMENT IS REQUIRED AT THE TIME OF SERVICE.
Failed appointments and late cancellations will be billed at our regular session rate. I have read and agreed to these policies.

DATE: _____ SIGNATURE: _____

FOR OFFICE USE ONLY:

DIAGNOSIS: _____

ADDITIONAL INFORMATION: _____

FINAL DISPOSITION: _____

EVALUATION: _____ THERAPY: _____ THERAPIST: _____

Julia Hobbs Speech Pathology, Inc. _____

Child's Name: _____ Date of Birth: _____ Age: _____

BACKGROUND INFORMATION

Please explain your primary reason for having your child evaluated: _____

_____

_____

_____

How long have you been concerned? _____

Does your child seem to be aware of the problem? Yes_____ No _____

If *yes*, please explain your child's reactions or comments: _____

_____

HEALTH INFORMATION

BIRTH HISTORY

Describe any complications in your pregnancy and delivery: _____

_____

Child's birth weight:_____ Length of pregnancy: _____

Describe your child's overall health: _____

_____

Pediatrician: _____Phone #_____

Please list other physicians or dentists currently treating your child: _____

_____

Has your child ever had ear infections? Yes_____ No_____

if yes, please explain frequency and treatment prescribed: _____

_____

Is your child taking medications? Yes_____ No_____

If yes, please explain: _____

_____

Has your child had any surgeries, accidents, or allergies? Yes_____ No_____

If yes, please describe: _____

_____

When was your child's last hearing test? _____ Where? _____

Results? _____

Do you feel your child is experiencing any behavioral, social, or emotional problems? _____

_____

_____

SOCIAL INFORMATION

Please list the names and ages of everyone living In your home:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Does your child speak any other languages?

If Yes, Please Explain: _____

Is there a family history of any of the hollowing?

Speech or Hearing Problems: Yes_____ No_____ Emotional Problems: Yes_____ No_____

Learning Problems: Yes_____ No_____ Psychological Problems Yes_____ No_____

Birth Defects: Yes_____ No_____

Nane of School: _____ Grade Level: _____

_____

Describe your child's performance and adjustment to school: _____

_____

OTHER INFORMATION

How did you hear of Julia Hobbs Speech Pathology, Inc.? _____

Please provide the name(s) of any other specialists seeing your child: _____

_____

_____

HOW CAN WE BE OF THE MOST HELP TO YOU?

_____

_____

Person Completing Form: _____ Date: _____

Relationship To Child: _____

Thank You For Taking The Time To Complete This Form

Release of/for Information

Please inform our office as to whom you would like us to release a copy of you/your child's records to or from whom you would like us to receive the records from:

Re: _____
(Patient's Name)

To: _____
(Name)

_____
(Address)

_____

To: _____
(Name)

_____
(Address)

_____

_____ _____
(Patient/Guardian Signature) (Date)