STEPHEN F. AUSTIN STATE UNIVERSITY
Speech-Language Pathology Program
Stanley Center for Speech and Language Disorders
Nacogdoches, Texas

**Case History: Child**
**The information on this form is confidential and will be used for professional use only.**

**PATIENT**

Name: ___________________________ Sex: _____ Twin: _____ Adopted: ____

Date of Birth: _________ Age: ______ Child's Primary Language:________________

Child's race/ethnic group:

Caucasian, Non - Hispanic    Hispanic    African-American

Native American    Asian or Pacific Islander    Other: ___________

Guardian: ________________________ Relationship: ___________________________

Address:______________________________ City: _____________ State: _____ Zip Code: _______

Email Address: _______________________________________

Primary Phone Number: ____________________ Secondary Phone Number: __________________

Referred by: __________________________ Reason for referral: ______________________________

Other Doctors (Physicians/Dentists/Orthodontists/Psychologists) that provide care to this child:

| Name | Specialty | City |
|---|---|---|
| _________________________ | ______________________ | _____________________ |
| _________________________ | ______________________ | _____________________ |
| _________________________ | ______________________ | _____________________ |

**FAMILY**

Mother: ___________________________ Age: _______ Occupation: _______________________

Father: ____________________________ Age: ________ Occupation: ______________________

Child lives with:

Both Parents        Mother        Father

Adoptive Parents        Other: ______________________

Parents are:

Married        Separated        Divorced        Other: ________________________

If your child was adopted, at what age and from where? ____________________________________

List names and ages of brothers and sisters:

____________________________________ Age: ___________

____________________________________ Age: ___________

____________________________________ Age: ___________

____________________________________ Age: ___________

Have there been any of the following major changes in your family during the last year?

Change of Address        Accident or Illness        Divorce/Marriage

Parent Separation        Birth/Adoption        Death of Immediate Family

Is there a family history of any of the following? If so, please list the family member. (mother, father, etc.)

Hearing loss: _____________________

Speech/Language Problem: _____________________

Prematurity: _____________________

Blindness: _____________________

Malformation of head neck or ears: _____________________

Educational Difficulties: _____________________

Drug Use: _____________________

Cleft Palate: _______________________

Seizure Disorder: _______________________

Mental Illness: _______________________

Alcoholism: _______________________

Delayed Motor Development: _______________________

Low Birth Weight: _______________________

Other: _______________________

## PREGNANCY HISTORY:

Full Term          Premature _________________ weeks

Please describe any illness/hospitalization of mother during pregnancy:

___________________________________________________________

___________________________________________________________

___________________________________________________________

Drug/alcohol/medication use before or during pregnancy:     YES     NO

If yes, please explain: ___________________________________________________

____________________________________________________________________

## BIRTH HISTORY:

U conditions such as Mumps, German

Measles, X-Rays, Serious Accidents, etc. ____________________________________

____________________________________________________________________

____________________________________________________________________

Delivery:     Vaginal     Cesarean Delivery; Why? _________________________

Birth Weight: _________________

Complications/Treatments:     Yes     No; How long? __________________

Cord around neck?     Yes     No; How long? __________________

Breathing problems?     Yes     No; How long? __________________

Transfusions?     Yes     No; How long? __________________

Other? _____________________________________________________________

**MEDICAL HISTORY:** Does the child have any of the following (past or present):

| | | | | | |
|---|---|---|---|---|---|
| Chicken Pox: | Yes | No | Learning Disability: | Yes | No |
| Ear Infections: | Yes | No | Heart Problems: | Yes | No |
| Gastric Reflux: | Yes | No | Head Injury: | Yes | No |
| Hearing Loss: | Yes | No | High Fevers: | Yes | No |
| Cerebral Palsy: | Yes | No | Diabetes: | Yes | No |
| Developmental Delays: | Yes | No | Adenoidectomy: | Yes | No |
| ADD/ADHD: | Yes | No | Tonsillitis: | Yes | No |
| Asthma/Breathing Difficulties: | Yes | No | Vision Problems: | Yes | No |
| | | | Ear Tubes: | Yes | No |
| Allergies: | Yes | No | Serious Injuries/ operations: | Yes | No |

If you answered "yes" to any of the above - please explain:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

List current medications and their purpose:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**HEARING/VISION:**

Has your child ever had his or her hearing tested? Yes No

If yes, when? What were the results? ________________

__________________________________________________

Has your child's vision been tested? Yes No

If yes, when? What were the results? _________________

___________________________________________________

## MOTORIC DEVELOPMENT:

Normal development for head control (3-4 mos), sitting (6-7 mos), walking (12-15 mos), toilet training (2.5-3.5 years), & eating

Delayed or later development (complete all below) | Age achieved/further info:

| | | | Age achieved/further info: |
|---|---|---|---|
| Head Support: | YES | NO | ________________ |
| Unsupported sitting: | YES | NO | ________________ |
| Walking without holding on: | YES | NO | ________________ |
| Trained for bowel/bladder: | YES | NO | ________________ |
| Does he/she have any accidents? | YES | NO | ________________ |
| Does/did child have difficulty sucking? | YES | NO | ________________ |
| Does/did child have difficulty chewing? | YES | NO | ________________ |
| Does/did child drool? | YES | NO | ________________ |

Current diet: Regular Cut up foods Baby food stage Other: ________________

## SPEECH HISTORY

Normal development for babbling (3-6 mos), first words (12-16 mos), & combining word phrases/ sentences (2-3 yrs)

Delayed or later development (complete all below)

| | | | Age achieved/further info: |
|---|---|---|---|
| Babble: | YES | NO | ________________ |
| Meaningful words: | YES | NO | ________________ |
| Combine 2-3 words: | YES | NO | ________________ |

Does your child understand directions: YES NO

Comments: ________________________________________________

________________________________________________

**SPEECH HISTORY**

What languages are spoken at home? ________________________________________

Which languages are spoken by the child?_____________________________________

Which languages are understood by the child? __________________________________

Do you feel that your child has a speech/language problem? Yes No

If yes, please describe: _______________________________________________________

If yes, who first noticed the problem and when? ___________________________________

Has your child ever had a speech evaluation/screening? Yes No

If yes, when, where and what were you told?____________________________________

_________________________________________________________________________

_________________________________________________________________________

Has your child ever had speech-language therapy? Yes No

If yes, when and where?__________________________________________________

Has your child ever received any other evaluations or therapy? Yes No

If yes, please describe: _________________________________________________

Is your child aware of, frustrated by, any speech/language difficulties? Yes No

If yes, please describe: _________________________________________________

What do you see as your child's most difficult problems?____________________________

_________________________________________________________________________

_________________________________________________________________________

My Child... *Check all that apply*

- Repeats sounds, words, or phrases over and over
- Understands words
- Understands sentences
- Understands conversation
- Retrieves/points to common objects upon request
- Follows 1 - step directions
- Follows 2 - step directions
- Responds correctly to yes/no questions
- Responds correctly to "wh" questions
- Asks questions of others

**My child currently communicates using...**

Crying or tantrums

Body language (i.e. pointing, looking, gesturing)

Sounds (i.e. vowel sounds, grunting)

Single words

2 to 4 word sentences

Sentences longer than 4 words (provide example):

_______________________________________________________

Other: _________________________________________________

**If your child typically is using words or sentences, please indicate if he/she is difficult to understand:**

By you: Yes No By others: Yes No

**If you answered "yes", How? (check all the apply)**

Speech sounds:

Omits sounds

Distorts sounds

Substitutes sounds

Other: _______________

Language:

Word order

Omits words

Speaks in only words/phrases

Other:_______________

Fluency/Voice:

Word or sound repetitions

Frequent and/or long pauses

Frequent use of "um" or "uh"

Unusual vocal quality or volume

## SOCIAL INTERACTION/PLAY

Behavioral Characteristics:

| | |
|---|---|
| Cooperative | Restless |
| Attentive | Poor eye contact |
| Willing to try | Easily distracted/short attention |
| Plays alone for reasonable length | Destructive/aggressive |
| Separation difficulties | Withdrawn |
| Easily frustrated/impulsive | Inappropriate behavior |
| Stubborn | Self-abusive behavior |

Describe any discipline problems you have with your child: ____________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How does your child respond to discipline? ________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## EDUCATIONAL HISTORY

No School

Preschool

Elementary School

Home schooled

Early Intervention

School name/telephone number: ________________________________________________

How many days per week; half day or full day? ____________________________________

Grade: __________ Teacher's name: ____________________________________________

Does your child have any concerns with attention, communication, or learning at school?

_________________________________________________________________________

Please describe any special tutoring/therapy: ___________________________________

_________________________________________________________________________

How does your child feel about school and his/her teachers? ______________________

_________________________________________________________________________

__________________________________
Person Completing Form (Print)

____________________________
Relationship to Client

____________________________
Date

# CONSENT FOR COMMUNICATION

Clients frequently request that we communicate with them by phone, voicemail, email, or text. The Stanley Center for Speech and Language Disorders respects your right to confidential communication about your protected health information (PHI), as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide for us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. The Stanley Center for Speech and Language Disorders will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

Please indicate below what types of communication you give your consent for anyone at the Stanley Center for Speech and Language Disorders to use:

☐ I do not give my consent to use voicemail, email or texting communication

☐ I consent to receive communication using the following means (check all that you consent to):

☐ Email
☐ Text
☐ Voicemail

E-mail address you are consenting to communicate through: ___________________________

Phone numbers you are consenting to communicate through (please list all):

_________________________________________________________________________________

Client Name: ________________________

Client Signature or Authorized Representative/Guardian Signature: ______________________

Date: __________________

## PERMISSION FOR TESTING AND TREATMENT

Approval is hereby given for our child to receive the appraisal services and treatment if warranted offered by the Stephen F. Austin State University's Stanley Center for Speech and Language Disorders. I understand that this evaluation and treatment will be done in the interest of the child's education development and will be supervised by a state licensed and ASHA certified Speech-Language Pathologist.

Signed: ________________________________

________________________________
Relationship to Patient

## PERMISSION TO RECORD/PHOTOGRAPH/OBSERVE

I hereby authorized the Stephen F. Austin Stanley Center for Speech and Language Disorders, exercising due discretions, for education and scientific/professional purposes, as in the public interest, to make customary and constructive use of information, photographs, and sounds recording, films and other records or materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child(ren) ________________________________ for whom I am legally responsible. The student clinician assigned may copy reports for the development of treatment plans.

Signed: ________________________________

________________________________
Relationship to Patient

## PROTECTED HEALTH INFORMATION

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. I understand how the clinic will utilize my or my child's protected health information (PHI) and my rights regarding my protected health information.

______________________________________ ______________________________
*Client or Legal Guardian* *Date*

# Stephen F. Austin State University
# Stanley Center for Speech and Language Disorders

## AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

______________________________ ______________________________

CLIENT NAME DATE OF BIRTH

I undersigned, authorized the Stephen F. Austin State University Stanley Center for Speech and Language Disorders to acquire and/or release professional information to:

______________________________

Agency/Individual Name

______________________________

Address

______________________________

Phone Number

For the purpose of:

______________________________________________________________________

______________________________________________________________________

I authorize release of the following:

______________________________________________________________________

______________________________________________________________________

I understand that I may revoke this authorization by submitting a written request to the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. Such a revocation does not apply to releases prior to the date of the request.

______________________________ ______________________________

*Client or Legal Guardian* *Date*

**Please Mail, Fax or E-mail Records to:**

Speech-Language Pathology Program

**Mail:** P.O. Box 13019, SFA Station

Nacogdoches, TX 75962

**Fax:** (936) 468-7096

**E-Mail:** petersend@sfasu.edu

**NAME OF CLIENT (PRINT) ___________________________**

## BILLING

Fees will be calculated on a per-session basis using the following coding:

- Initial Evaluation - $75/evaluation
- Re-Evaluation (existing clients) – If completed during therapy sessions, the regular therapy session rate applies. If completed during an additional session(s) cost will be $30 (you will not be billed for more than one re-evaluation per year.)
- Treatment Session - $15/session

Initial evaluations must be paid the day of the evaluation.

Treatment sessions must be paid the day of services or if you prefer to pay for the entire week at once, you may pay the last day of therapy of each week.

In order to continue therapy, balance for services must be paid in full each week.

**Qualification for reduced fees:**
If you meet any of the criteria below you are eligible for a reduction in fees. Please fill out the section that pertains to you, so that reduction in fees can be verified.

1. Employee of SFASU
   Name: ___________________________
   CID # ____________________________
   If you are an employee of SFASU, you and dependent children are eligible for 50% off services.
   Name of Dependent: ____________________________
2. Full time student at SFASU
   Name: ___________________________
   CID # ____________________________
   If you are a full-time student at SFASU, you and dependent children are eligible for 50% off services.
   Name of Dependent: ____________________________
3. Full time student in the CSDS or Speech Language Pathology Program
   Name ___________________________
   CID# ____________________________
   Student will receive free services. Does not apply to dependents or family members.
4. Qualify for Medicaid/CHIP or Medicare
   Name: ___________________________

Copy of Medicaid/Medicare card must be provided
Coverage Dates on Card: ____________________
Only the person receiving Medicaid/CHIP or Medicare are eligible for 50% off services.

5. Receiving SPEAK OUT! or LOUD Crowd services
   Name: __________________________
   Services are free due to a Grant from Parkinson's Voice Project.

**Account Balances and Payment Responsibility:**

- Clients must pay for evaluations the day of the evaluation.
- Clients receiving therapy must pay their account balances each week.
- In order to continue therapy, balance for services must be paid in full each week.
- Clients who have questions about their bill or would like to discuss a payment plan arrangement may contact the front office at: (936) 468-7109.
- Failure to pay balance by the end of the semester will result in dismissal from therapy.

I understand that I am responsible for all charges for the services rendered to me or my dependents regardless of insurance. Failure to pay all applicable fees when due may result in the University taking action in law or equity, and/or using the services of a collection agency to collect any unpaid balance. The client/guardian agrees to pay to University its expenses incurred with collection of the unpaid balance, including attorneys' fees, court costs, collection agency fees, and any relief to which the University may be entitled.

_____________________________ _____________________________
Printed Name (Person Responsible for Payment) Signature

_____________________________ _____________________________
Relationship to Client Date

# CANCELLATION/NO SHOW POLICY

The Stanley Center for Speech and Language Disorders is a teaching facility at SFASU. Graduate students are required to obtain a set number of clinical hours in order to get credit for their practicum in speech pathology, therefore it is important that clients come to therapy consistently.

1. **Cancellation/No Show Policy for Speech/Language Therapy Sessions**
    - We understand that there are times when you must miss an appointment due to emergencies or other obligations. However, when you do not call to cancel an appointment, you may be preventing your graduate clinician from getting required practicum hours.
        - Please notify the clinician or the clinic office at 936-468-7109 if you will be absent.
        - If an appointment is not cancelled in advance, you will be charged for that session.
    - Therapy time will be automatically terminated for the following reasons:
        - accumulation of 3 absences without notification
        - total of 6 missed sessions for any reason during a fall or spring semesters for bi-weekly therapy
        - total of 3 missed sessions for any reason during the fall or spring semesters for once-a-week therapy
        - *Exceptions will be made due if client has an extended illness. Documentation must be provided. If possible, teletherapy may be an option.
2. **Scheduled Appointments**
    - We know that delays can happen, however if you or the client are 15 minutes past their schedule therapy time without notification the appointment will be cancelled and viewed as “no show”.

I understand the Cancellation Policy and will agree to abide by the policy.

| ______________________________ | ______________________________ |
|---|---|
| Printed Name | Signature |
| ______________________________ | ______________________________ |
| Relationship to Client | Date |