Patient Information Form

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____ Age: _____
Last First MI mo day year

Gender: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referred by: _____ Primary Care Physician: _____

Other specialists involved in care: _____

Primary reason(s) for today's visit: _____

_____

Insurance Information

Person Responsible for Account: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Employer: _____

Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Group Number: _____ ID Number: _____

Address: _____

Insurance Phone Number (*usually found on back of insurance card):* _____

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____ Date: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ▯ Hearing Testing ▯ VRA ▯ VNG/VEMP ▯ OAE ▯ BAER/ECochG ▯ Hearing Aids ▯ Cochlear/Bone Implants ▯ Tinnitus ▯ CAPD ▯ EHDDI
Speech-Language Pathology ▯ Language ▯ Voice ▯ Accent Modification ▯ Autism ▯ Evaluation & Treatment ▯ Pediatric & Adults

Birth to Preschool Comprehensive Assessment

Patient Name: _____
Last *First* *MI*

Date of Birth: ___/___/_____ Today's Date: ___/___/_____
mo day year mo day year

Parent(s) Name(s): _____

Parent Phone Number: _____ Parent email: _____

Please list those living in the patient's home and their relationship to the patient: _____

_____

Pediatrician: _____ Date last seen by pediatrician: _____

Other specialists who have worked with this child (i.e. OT, PT, psych, etc.): _____

_____

Principle concern in seeking this evaluation: _____

_____

Prenatal and Birth History

Length of pregnancy: _____ Birthweight: _____

List any medications or drugs (including alcohol) taken during pregnancy: _____

_____

YES	NO	
□	□	Any illnesses, injuries, or complications during the pregnancy/ delivery?
□	□	Did the child require any special attention during his or her stay in the hospital?
□	□	Did the pediatrician have any special concerns during his or her first year?

Please elaborate if "YES" to any of the above: _____

Developmental History

Age when child first:

Smiled	_____	Spoke first word	_____
Sat alone	_____	Drank from a cup	_____
Crawled	_____	Ate solid food	_____
Walked	_____	Toilet trained	_____

Medical History

YES	NO	
□	□	Is the patient taking any medications? If yes, please list frequency and dose: _____
□	□	Has the patient's hearing been tested? If yes, please indicate test date and results: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

□ □ Is there a history of ear infections?
If yes, please describe the number, who diagnosed, and treatment: _____
_____

□ □ Have P.E. tubes been placed?
If yes, by whom and when? _____

□ □ Does the patient have a history of problems with chewing, feeding, swallowing, or drooling?
If yes, please describe: _____

Please describe any illnesses the patient has experienced (date and treatment): _____
_____

Please describe any injuries the patient has experienced (date and treatment): _____
_____

Please check areas in which you have possible health or developmental concerns:

□Hearing	□Behavior	□Physical health
□Large motor skills (walking, sitting, jumping)	□Small motor skills (drawing, writing, object manipulation)	□Vision
□Diet or eating	□Social interactions	□Self-help skills
□School achievement	□Balance/ coordination	□Eye contact
□Attention/ concentration	□Play skills	□Other: _____

Please explain any concerns: _____
_____

Educational and Academic History:
Does your child currently attend: □daycare □preschool □pre-kindergarten □none

If yes, at what age did they begin care? _____

What is the name of the daycare or preschool? _____

How frequently does your child attend daycare or preschool? _____

Have there been any concerns noted by daycare providers or preschool teachers? _____
_____

Does your child receive any special education services (i.e. IFSP, IEP, 504 plan, etc.)? _____
_____

Speech and Language History:
What prompted your concerns regarding this patient's speech and/ or language development? _____
_____
_____

Has the patient received previous speech, language, or learning therapy? □YES □NO

If yes, when and by whom? _____

Is there a family history of speech, language, or learning problems? □YES □NO

If yes, please describe: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

What language(s) is spoken in the home? _____

If the patient is learning more than one language:

Does he or she understand each language?_____

Does he or she use each language? _____

At what age was he or she exposed to each language? _____

Does the patient express frustration with communication? □YES □NO

If yes, how do they express this frustration? _____

Receptive Language

Do you have any concerns about the patient's ability to follow directions or understand what others are saying to him or her? □YES □NO

If yes, please describe: _____

Is the patient able to:

□Follow single step directions □Follow two step directions □Follow unfamiliar directions
□Understand questions □Identify body parts □Identify colors

Expressive Language

At what age did this child:

□No concerns □Babble (i.e. "gaga")? □Use single words?
□Put two words together? □Use longer phrases or sentences? □Identify colors?

How does this child communicate wants and needs? □Gestures □Sign language
□Single spoken words □Short spoken phrases □Spoken sentences

Articulation and Pronunciation

□no concerns

What percentage of the patient's speech is understood by:

Mother? _____ Peers? _____
Father? _____ Extended family? _____
Siblings? _____ Unfamiliar adults? _____

Please provide examples of speech errors that concern you (i.e. "wed" for "red"): _____
_____

Play and Social Development

□no concerns

What opportunities does the patient have to interact with other children his or her age? (i.e. Little Gym, classes, playground, etc.)_____

Do you have any concerns regarding the patient's play skills? □YES □NO

If yes, please describe: _____

Is the patient experiencing any difficulties interacting with □other children □other adults?

If yes, please describe: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology Hearing Testing VRA VNG/VEMP OAE BAER/ECochG Hearing Aids Cochlear/Bone Implants Tinnitus CAPD EHDDI
Speech-Language Pathology Language Voice Accent Modification Autism Evaluation & Treatment Pediatric & Adults

Does the patient demonstrate any difficulty change to or from activities? □ YES □ NO

If yes, please describe: _____

Fluency and Stuttering

□No concerns

When did the dysfluency/ stuttering first start or become noticeable? _____

Was the onset sudden or gradual? Please explain. _____

Is there a family history of stuttering? □ YES □ NO

If yes, please indicate the relationship to child: _____

How does the family typically respond during a moment of stuttering? _____

_____

Does the child demonstrate any frustration with his or her stuttering? _____

_____

I have noticed increased stuttering on a regular basis when the patient is:

□ Tired
□ Speaking with peers
□ Speaking with strangers
□ Speaking with siblings
□ Excited
□ Speaking with extended family
□ Telling stories
□ Other: _____
□ Speaking with family
□ At school
□ Talking on the phone

Please check behaviors observed during moments of stuttering with the patient:

□ Repeats parts of words (ca-ca-cat)
□ Repeats phrases
□ Blocks (often looks like words get stuck)
□ Excessive or unusual eye blinking
□ Unusual changes inloudness or pitch
□ Avoids eye contact
□ Other: _____
□ Repeats whole words (my-my-my game)
□ Prolongs certain sounds
□ Demonstrates tension in the face or body
□ Excessive or unusual hand or body movements
□ Avoids certain words
□ Interjections (um, like, you know)

Please rate the patient's stuttering on a scale of 1-10 (1=no stuttering, 10= most severe stuttering): _____

Please rate the patient's stuttering behaviors on a typical day (1=never, 2= rarely, 3= sometimes, 4= often, 5=always)

1	2	3	4	5	The patient's stuttering worries me
1	2	3	4	5	The patient avoids speaking situations because of his/her stuttering
1	2	3	4	5	Other people have noticed the patient's stuttering
1	2	3	4	5	The patient's stuttering interferes with peer interactions

Voice

□ No concerns

When did voice concerns first start or become noticeable? _____

Have you consulted with your primary care physician or an ENT regarding this change? □ YES □ NO

If yes, please explain: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Was the onset sudden or gradual? _____

Are there times you notice improved vocal quality? □ YES □ NO

If so when? _____

In what situations is vocal quality worse? _____

Please check characteristics that concern you:

□Hoarseness/ raspiness
□Too quiet or whispers
□Unusual changes in loudness or pitch
□Complaints of pain or fatigue
□Too loud
□Other: _____

Please rate the following activities for the patient (1: never, 2: rarely, 3: sometimes, 4: often, 5: always)

1	2	3	4	5	Aggressive throat clearing
1	2	3	4	5	Imitate other voices or characters while playing
1	2	3	4	5	Cries often
1	2	3	4	5	Screams
1	2	3	4	5	Talks loudly
1	2	3	4	5	Yells or cheers
1	2	3	4	5	Sings
1	2	3	4	5	Performs vocally (acts, sings, cheerleads)
1	2	3	4	5	Participates in sports
1	2	3	4	5	Other family members yell or cheer

Please provide any additional information that you feel may be relevant to this child's communication difficulty.

Your comments and opinions are very important. _____

_____

_____

_____

Patient Name: _____
Date of Birth: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Systems History

Ears, Nose, Throat, and Mouth

EARS
- ❑ Hearing loss
- ❑ Consistent ear infections
- ❑ Placement of PE tubes (when? _____)
- ❑ Skin tags or pits near the ears
- ❑ Struggle with hearing in noisy places
- ❑ **No concern**

NOSE
- ❑ Chronic congestion
- ❑ Frequent sinus infections
- ❑ Trouble breathing through nose
- ❑ **No concern**

THROAT
- ❑ Painful swallowing
- ❑ Pain or discomfort after talking
- ❑ Hoarseness
- ❑ Frequent throat clearing
- ❑ Feeling of something 'stuck' in throat
- ❑ **No concern**

MOUTH
- ❑ Oral habits (e.g. thumb sucking, use of pacifier, sucking on shirt strings)
- ❑ Difficulty transitioning to solids
- ❑ Difficulty chewing
- ❑ Coughing frequently while eating
- ❑ Constant dry mouth
- ❑ **No concern**
- ❑ Other:_____

Cardiovascular
- ❑ Chest pain or discomfort
- ❑ Shortness of breath with exertion
- ❑ **No concern**
- ❑ Other:_____

Psychiatric
- ❑ Anxiety or stress
- ❑ Depression
- ❑ Sleep problems
- ❑ **No concern**
- ❑ Other:_____

Vision

ACUITY
- ❑ Nearsighted
- ❑ Farsighted
- ❑ Astigmatism
- ❑ **No concern**

VISUAL PROCESSING
- ❑ Blurred vision
- ❑ Double vision
- ❑ Difficulty tracking
- ❑ Complaints of objects moving while trying to focus
- ❑ Dyslexia
- ❑ **No concern**
- ❑ Other:_____

Respiratory
- ❑ Asthma
- ❑ Apnea/Dyspnea
- ❑ Shortness of breath
- ❑ Frequent episodes of pneumonia, bronchitis, or other infections
- ❑ Trouble achieving adequate breath support
- ❑ **No concern**
- ❑ Other:_____

Neurological
- ❑ Dizziness
- ❑ Frequent headaches
- ❑ Weakness
- ❑ Tremors
- ❑ Seizures
- ❑ Memory loss
- ❑ Poor attention
- ❑ History of brain injury or concussions
- ❑ **No concern**
- ❑ Other:_____

Skin
- ❑ Rashes
- ❑ Acne
- ❑ Eczema
- ❑ **No concern**
- ❑ Other:_____

Musculoskeletal
- ❑ Muscle/joint pain
- ❑ Back pain
- ❑ Scoliosis
- ❑ **No concern**
- ❑ Other:_____

Gastrointestinal/ Genitourinary
- ❑ Heartburn or reflux
- ❑ Frequent nausea/ vomiting/ diarrhea
- ❑ Constipation
- ❑ Nighttime urination
- ❑ Kidney problems
- ❑ Struggle potty-training
- ❑ **No concern**
- ❑ Other:_____

Allergies
- ❑ Seasonal allergies
- ❑ Food allergies

Details: _____
- ❑ Medication allergies

Details: _____
- ❑ **No concern**
- ❑ Other:_____

Motor Development

FINE MOTOR
- ❑ Poor handwriting
- ❑ Trouble grasping small objects
- ❑ Trouble opening or closing screw-lid containers
- ❑ Trouble coordinating vision with hand movements (e.g. putting a puzzle together)
- ❑ **No concern**

GROSS MOTOR
- ❑ Trouble balancing
- ❑ Falls often
- ❑ Easily trips over objects
- ❑ **No concern**
- ❑ Other:_____

Previous Diagnoses

Please check all previous diagnoses.
- ❑ ADD
- ❑ ADHD
- ❑ Autism
- ❑ Asperger's Syndrome
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Cognitive Impairment
- ❑ OCD
- ❑ **No concern**
- ❑ Other:_____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology • Hearing Testing • VRA • VNG/VEMP • OAE • BAER/ECochG • Hearing Aids • Cochlear/Bone Implants • Tinnitus • CAPD • EHDDI
Speech-Language Pathology • Language • Voice • Accent Modification • Autism • Evaluation & Treatment • Pediatric & Adults

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth:_____

I acknowledge that I received a copy of Evergreen Speech & Hearing Clinic, Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Evergreen Speech & Hearing Clinic, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Evergreen Speech & Hearing Clinic, Inc may use and share my health information for other than treatment, payment, and health care operations.
- Evergreen Speech & Hearing Clinic, Inc. will also use and share my health informa tion as required/permitted by law.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

Kirkland Office • 12333 NE 130th Lane, #430 • Kirkland, WA 98034 • 425.899.5050 Fax - 425.899.5054
Bellevue Office • 1800 116th Ave NE, #103 • Bellevue, WA 98004 • 425.454.1883 Fax - 425.454.2036
Redmond Office • 8301 161st Ave NE, #208 • Redmond, WA 98052 • 425.882.4347 Fax - 425.882.0043

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979
www.everhear.com

Audiology • Hearing Testing • VRA • VNG/VEMP • OAE • BAER/ECochG • Hearing Aids • Cochlear/Bone Implants • Tinnitus • CAPD • EHDDI
Speech-Language Pathology • Language • Voice • Accent Modification • Autism • Evaluation & Treatment • Pediatric & Adults

Bellevue Office
1800 116th Ave NE #103
Bellevue, WA 98004
F: 425.454.2036
P: 425.454.1883

Kirkland Office
12333 NE 130th Ln #430
Kirkland, WA 98034
F: 425.899.5054
P: 425.899.5050

Redmond Office
8301 161st Ave NE #208
Redmond, WA 98052
F: 425.883.0043
P: 425.882.4347

Treatment A/V Authorization Form

Name of the person in treatment:_____

During your or your child's treatment sessions your speech-language pathology team may wish to use audio or visual (A/V) recording for further analysis, communication between treating clinicians, progress docu-mentation, grand rounds session and/or educational purposes. This material will not be used for marketing, advertisement, or external communications without further consent.

Please check a box below to indicate if A/V recordings can be used during treatment session.

☐ Evergreen Speech & Hearing Clinic **has my permission** to use A/V recordings during therapy sessions.
☐ Evergreen Speech & Hearing Clinic **does not have my permission** to use A/V recordings during therapy sessions.

_____

Signature Date

If under 18, a parental or guardian signature is required

_____

Parental/Guardian Signature Date

_____

Speech-Language Pathologist Signature Date