



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

Primary Insurance Company: _____

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

Group Number: _____ ID Number: _____

Secondary Insurance Company: _____

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

Group Number: _____ ID Number: _____

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: _____



School Age 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: _____
- ☐ ☐ 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? _____



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Date of Birth: _____

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- ☐ ☐ 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:

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

Please explain any concerns: _____

Educational and Academic History:

What grade is the patient in? _____ What school does the patient attend? _____

Have there been any concerns reported by teachers? _____

Does the patient receive any services or support within the school environment? _____

Does the patient currently receive any accommodations from an ☐IEP ☐IFSP ☐504B ☐none

If yes, please elaborate: _____

Does the patient receive any tutoring? ☐YES ☐NO

If yes, where? _____

Does the patient exhibit difficulty with any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Completing homework assignments | <input type="checkbox"/> Turning homework assignments in on time |
| <input type="checkbox"/> Keeping schoolwork organized | <input type="checkbox"/> Keeping up with the class |
| <input type="checkbox"/> Following directions in class | <input type="checkbox"/> Sustaining attention |
| <input type="checkbox"/> Reading decoding/ fluency | <input type="checkbox"/> Reading comprehension |
| <input type="checkbox"/> Written organization | <input type="checkbox"/> Handwriting |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Math |

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: _____

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: _____

Does the patient answer questions appropriately? ☐ YES ☐ NO

If no, please explain: _____

Expressive Language

Do you have concerns about the patient's ability to:

☐ Think of the right words

☐ Use appropriate word order

☐ Use appropriate grammar

☐ Talk about events that will happen

☐ Talk about events that already happened

☐ Use specific words (vs. overuse of words like "this", "over there", etc.)

☐ Express feelings and opinions

☐ Ask questions

☐ Participate in conversation

☐ Tell a story

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"): _____

Social Development

☐ no concerns

What extracurricular activities does the patient participate in? _____

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

If yes, please describe: _____

In new situations, the patient:

☐ Adapts easily

☐ Quickly warms up

☐ Is shy

☐ Demonstrates anxiety

☐ Has limited or no participation

☐ Is slow to warm up

☐ Other: _____



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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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Tired | <input type="checkbox"/> Excited | <input type="checkbox"/> Speaking with family |
| <input type="checkbox"/> Speaking with peers | <input type="checkbox"/> Speaking with extended family | <input type="checkbox"/> At school |
| <input type="checkbox"/> Speaking with strangers | <input type="checkbox"/> Telling stories | <input type="checkbox"/> Talking on the phone |
| <input type="checkbox"/> Speaking with siblings | <input type="checkbox"/> Other: _____ | |

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

- | | |
|--|--|
| <input type="checkbox"/> Repeats parts of words (caca-cat) | <input type="checkbox"/> Repeats whole words (my-my-my game) |
| <input type="checkbox"/> Repeats phrases | <input type="checkbox"/> Prolongs certain sounds |
| <input type="checkbox"/> Blocks (often looks like words get stuck) | <input type="checkbox"/> Demonstrates tension in the face or body |
| <input type="checkbox"/> Excessive or unusual eye blinking | <input type="checkbox"/> Excessive or unusual hand or body movements |
| <input type="checkbox"/> Unusual changes in loudness or pitch | <input type="checkbox"/> Avoids certain words |
| <input type="checkbox"/> Avoids eye contact | <input type="checkbox"/> Interjections (um, like, you know) |
| <input type="checkbox"/> Other: _____ | |

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: _____

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:

- | | |
|---|--|
| <input type="checkbox"/> Hoarseness/ raspiness | <input type="checkbox"/> Complaints of pain or fatigue |
| <input type="checkbox"/> Too quiet or whispers | <input type="checkbox"/> Too loud |
| <input type="checkbox"/> Unusual changes in loudness or pitch | <input type="checkbox"/> Other: _____ |



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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. _____



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: _____



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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 information as required/permitted by law.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date



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 documentation, 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