HASA
CIRS Interpreting @ Gateway School
Hearing and Speech-Language Services

CHILD/PRESCHOOL CASE HISTORY
(Age 5 and under)

I. GENERAL INFORMATION

Child's Name _____ Birth Date_____ Female ☐ Male ☐

Address _____

Street *City/County* *State* *Zip*

Home Phone_____ Cell Phone_____

Primary E-mail Address (if a desired means of communication) _____

Social Security Number_____ MA#_____ Race: (optional)_____

Insurance Carrier_____ Member ID #_____ Group #_____

Name on Card_____

Referred By_____

Child's Physician _____Phone_____

Address_____

Does Your Child (please check) ☐attend preschool ☐attend daycare ☐stay with a sitter

School/Day Care Name and Address_____

II. FAMILY INFORMATION

Mother/Legal Guardian Name_____ Employer/Occupation _____

_____ Work Phone _____

Parent ☐ Legal Guardian ☐ Home Phone _____

Address (if different from child's) _____ Cell Phone _____

_____ Email _____

Education _____

Father/Legal Guardian Name_____ Employer/Occupation _____

_____ Work Phone _____

Parent ☐ Legal Guardian ☐ Home Phone _____

Address (if different from child's)_____ Cell Phone _____

_____ Email _____

Education _____

It there court ordered custody? ☐ Yes ☐ No
If yes, who has guardianship? Name_____
☐ Full ☐ Partial ☐ Temporary Phone _____Email_____
Name_____
☐ Full ☐ Partial ☐ Temporary Phone _____Email_____
Social Worker Name_____ Phone_____ Email_____
Attorney Name_____ Phone_____ Email _____
Child's brothers and sisters (names and ages) _____
Who lives in the home with the child?_____
Is there more than one language spoken at home? If so, what is the primary language and what is/are the secondary language(s)?☐ Yes ☐ No If so, _____
Has anyone in your family had a speech, hearing, reading, or language difficulty? Yes ☐ No ☐
If yes, please explain relationship and difficulty experienced. _____
_____

III. DESCRIPTION OF CHILD'S SPEECH/LANGUAGE PROBLEM

I am concerned about my child's (check all that apply):
☐understanding of language ☐ability to communicate ☐ speech clarity ☐ social interaction ☐stuttering
Please describe your concerns _____
When was the problem first noticed? _____
Has the problem ☐improved ☐worsened ☐ remained the same since it was first noticed?
Please explain _____
Are there situations in which your child has particular difficulty? ☐Yes ☐ No
If yes, please describe _____
Have any other specialists (speech-language pathologists, physicians, psychologists, special educators, occupational therapists, audiologists, etc.) seen your child for an evaluation or treatment? If yes, please indicate below. Please provide copies of any past reports/evaluations.

Specialty & Provider Name	Phone	Date(s) Seen	Outcome

IV. PREGNANCY AND BIRTH HISTORY

Did the pregnancy go to full term? ☐ Yes ☐ No If no, how many weeks early?_____
Were there any complications/maternal health problems with this pregnancy? (e.g., infection, toxemia, hospitalization, drugs, etc.) ☐ Yes ☐ No If yes, please describe_____
Check type of delivery: ☐head first ☐feet first ☐breech ☐Cesarean
If C-section, reason _____
Baby's birth weight _____ General health of baby at birth_____
Was baby in NICU or did he/she receive any special care post-birth? Yes ☐ No ☐
If yes, please explain _____
Age of baby when discharged home following birth _____

V. MEDICAL/HEALTH HISTORY

Has child ever been hospitalized or had any surgeries? Yes ☐ No ☐
If yes, please explain when and why _____
Does child take any medication? Yes ☐ No ☐
If yes, please list medication(s) _____
Does child have any significant medical problems/illnesses? Yes ☐ No ☐
If yes, please describe _____

Does child have any of the following? Describe when needed.

Allergies	Yes ☐	No ☐	Unsure ☐	_____
Asthma	Yes ☐	No ☐	Unsure ☐	_____
Birth defects	Yes ☐	No ☐	Unsure ☐	_____
Bleeding disorder	Yes ☐	No ☐	Unsure ☐	_____
Diabetes	Yes ☐	No ☐	Unsure ☐	_____
Hearing problems	Yes ☐	No ☐	Unsure ☐	_____
Seizures	Yes ☐	No ☐	Unsure ☐	_____
Vision problems	Yes ☐	No ☐	Unsure ☐	_____
Other_____	Yes ☐	No ☐	Unsure ☐	_____

Has your child ever been tested for blood lead levels (lead poisoning)? Yes ☐ No ☐ Unsure ☐
If yes, results?_____
Does the child have difficulty walking, running, holding items or participating in other activities that require small or large muscle coordination? _____
Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, constant open mouth, etc.) If yes, please describe _____
Does child use a pacifier or suck his/her thumb? ☐ Yes ☐ No _____
Was your child breast fed ☐ or bottle fed ☐? Until what age?_____
Were there any problems with breast or bottle-feeding? If so, specify_____
Is your child drinking from a cup without assistance or without losing any liquid from the mouth?
Yes ☐ No ☐
Does your child stuff or cram food into his/her mouth while eating? Yes ☐ No ☐
Does your child feed him /herself? Yes ☐ No ☐ How? _____

What are your child's food preferences? (Taste/Texture) _____
My child won't eat _____
Does your child drool? Yes ☐ No ☐
Does your child put his/her fingers or non-food objects into mouth? Yes ☐ No ☐

VI. DEVELOPMENTAL MILESTONES

Speech/Language	Age	Motor/Self-Help	Age
Imitated/repeated sounds	_____	Sat alone	_____
Said first word	_____	Crawled	_____
Regularly used single words	_____	Stood alone	_____
Used two-word phrases	_____	Walked alone	_____
Spoke in sentences	_____	Toilet trained	_____
Asked simple questions	_____	Fed self	_____
		Dressed self	_____

VII. HEARING HEALTH HISTORY

Has child had ear infections? Yes ☐ No ☐
If yes, how many? _____When?_____
Has child's hearing been tested? Yes ☐ No ☐
If yes, where? _____When?_____ Results? _____
Do you think your child has a problem hearing? Yes ☐ No ☐
If yes, please explain _____
Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.) _____

VIII. SPEECH/LANGUAGE DEVELOPMENT AND SKILLS

Is your child able to understand: (check as many as applicable)
☐gestures ☐words ☐short phrases ☐sentences

How does your child usually communicate? Check all that apply:

☐pointing/gestures	☐sounds/grunting	☐babbling (sound repetitions like baba, dada
☐ jargon (nonsense words that sound like a different language)	☐single words	☐short phrases
☐ uses complete sentences	☐uses conversation	☐ asks questions
☐repeats nursery rhymes/songs	☐retells simple stories	☐other_____

Does your child use more than 20 words? Yes ☐ No ☐
(insert list of fist words BITP) If no, please list the words he/she uses _____
_____

Does child respond to his/her name?	Yes ☐	No ☐
Does child make appropriate eye contact when speaking/interacting with others?	Yes ☐	No ☐
Does child point to body parts on request?	Yes ☐	No ☐
Does child point to pictures in a book on request?	Yes ☐	No ☐
Does child follow simple directions?	Yes ☐	No ☐
Does child understand simple "wh" questions?	Yes ☐	No ☐
Does your child answer yes/no questions appropriately with a head movement or word?	Yes ☐	No ☐

Will she/he retrieve familiar objects when asked? Yes ☐ No ☐
Do gestures have to be used for your child to understand words, short phrases, or sentences? Yes ☐ No ☐
Does child use sentences of two to three words? Yes ☐ No ☐
Does child use sentences of four or more words? Yes ☐ No ☐
Does family understand child's speech? Yes ☐ No ☐
Do other people understand child's speech? Yes ☐ No ☐
Does your child have difficulty producing specific speech sounds? If yes, please list which sounds if known Yes ☐ No ☐

_____

Does your child hesitate or repeat sounds or words when talking? Yes ☐ No ☐

Please describe _____

Does the child "get stuck" when attempting to say a word? Yes ☐ No ☐
Is the child aware of his/her communication difficulties? Yes ☐ No ☐ ☐Unsure
If "yes," how does this awareness impact on the child's social/emotional status?

_____

How does your child greet someone when that person is arriving or leaving the room?

_____

What does your child do when he/she needs help (e.g., opening a container, working a toy, reaching for objects)?_____

_____

How does your child attract your attention if you are busy doing something (e.g., talking with an adult, preparing a meal)?_____
Does your child like to play social games with you (e.g., "peek-a-boo," "I'm gonna get you," etc.) Which ones? _____
How does your child ask to play these games or keep the game going?

_____

Does your child ask questions that start with (check all that apply):
☐Who? ☐What? ☐Where? ☐Why? ☐ When? ☐ How?

IX. PLAY BEHAVIORS/SOCIAL SKILLS

Does child play with toys? Yes ☐ No ☐
If yes, what toys does he/she enjoy playing with? _____
Does he/she enjoy or avoid the company of other children? ☐Enjoys ☐ Avoids
Describe_____
Does the child prefer playing with you or by him/herself?_____
Do you feel the child's attention span is normal for his/her age? Yes ☐ No ☐
If no, please describe _____

Please check the behaviors that you feel best describe the child:

☐Defiant
☐Overly quiet
☐Easily controlled/passive
☐Friendly, outgoing
☐Difficulty separating from parents
☐Very shy
☐Excessive tantrums
☐Nervous
☐Perfectionist
☐Prefers younger children
☐Able to initiate interaction
☐Flexible, able to work outside the routine
☐Destructive
☐Dependent upon routines
☐Imaginative and creative
☐Plays well with peers
☐Prefers older children
☐Able to maintain interactions
☐Easily distracted
☐Overly active

Evaluations for this age group typically range from 60 to 120 minutes. Please provide preferred day(s) of

the week and time of day for the evaluation. If there are no particular preferences, please provide days/times that you are unavailable (if any). We cannot guarantee a particular time but this will give us a guideline when assigning your child's case. _____
_____

If therapy is warranted, your child will be assigned a standing weekly therapy appointment that is his/hers alone. Please provide preferred days/times for therapy (typically 30 minutes 1 or 2 times per week). If you have no specific preferences, please provide days/times that you are unavailable, as well as preference for morning or afternoon. Consider naptimes, work schedules, etc. _____
_____

Is there anything else that you think is important for us to know before we see your child? Use additional pages if necessary.

_____
_____
_____

***** Please remember to provide copies of other evaluations that your child has had.*****

Form completed by _____ Date _____

Relationship to child _____

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FINANCIAL INFORMATION

Financially Responsible Party If Other Than the Patient

Name:_____ Relationship to Patient:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Secondary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Form Completed by:_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

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Permission to Obtain & Release Information

Client Name_____ Date of Birth_____

Please note that per Medicaid guidelines, we must release all evaluation and treatment notes to your child's pediatrician.

If you would like for your child's evaluation and progress notes to be sent to an additional physician, please list below:

Physician Name _____

Physician Address_____

Phone Number _____ Fax Number_____

I hereby authorize The Hearing and Speech Agency of Metropolitan Baltimore, Inc. to obtain/release pertinent clinical and/or educational information in written and/or oral form regarding evaluation, treatment, or ongoing progress for the above-named person, in the following disciplines:

☐ Audiology ☐ Education ☐ Medical ☐ Occupational Therapy

☐ Psychology ☐ Social Work ☐ Speech-Language Pathology ☐ Other

If you do not have Medicaid, your child's notes will automatically be sent to the physician on file unless otherwise noted.

☐ I do not want my information or records released to anyone.

_____ _____
Client (Parent or Guardian if client is a minor) Date

_____ _____
Witness Date

This consent will be in effect for one year from the date of signature. It may be revoked or revised in writing at any time by the person giving permission on this form or by a minor child who reaches the age of majority during the effective year.

THE HEARING AND SPEECH AGENCY
Harry & Jeanette Weinberg Building | 5900 Metro Drive | Baltimore, MD 21215 | www.hasa.org
(p) 410.318.6780 | MD RELAY 711 | (f) 410.318.6759 | (e) hasa@hasa.org

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CONSENT FOR TREATMENT:
I hereby authorize the personnel of The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to release my diagnosis and other medical information to the third party payer identified to determine benefits payable. Reports will be sent to me electronically or via fax unless otherwise noted. **Please remove The Hearing and Speech Agency from your SPAM folder**.

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment to The Hearing and Speech Agency of any insurance otherwise payable to me or the patient. I acknowledge the responsibility for any coinsurance, deductible, and/or other sum not received by The Hearing and Speech Agency from any third party source.

GUARANTEE OF PAYMENT:
I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay The Hearing and Speech Agency's charge in full when rendered. Once the bill has been submitted to the insurance company, changes to procedures or diagnostic codes cannot be made. I also acknowledge that interest may be charged to unpaid balances over 30 days from the date payment is due. In the event that the account is referred for collections, I agree to pay for all collection and attorney fees required to collect any delinquent balance.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (Applies to Medicare Patients Only):
I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payers is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

PERSONAL VALUABLES:
Patients are encouraged to leave all valuables at home. The Hearing and Speech Agency is not responsible for the loss of or damage to any personal property the patient has brought into The Hearing and Speech Agency.

PATIENT RIGHTS AND RESPONSIBILITIES:
I have been notified about patient rights and responsibilities including Privacy Practices.

I permit a copy of this authorization to be used in place of the original.

I certify that I understand the contents of this form.

Client Name	Guardian Name	Client/Guardian Signature	Date