Simone Hüls, Ph.D., CCC-SLP
Licensed Speech-Language Pathologist (CA SP 25805)
Phone: 805-858-9222 x700 Fax: 805-460-6818
Email: speechwithsimone@gmail.com
Website: www.speechwithsimone.com
Office: 5975 Entrada Ave. Atascadero, CA 93422

Child's Name: ________________________________Date of Birth: _________________________________

Parent/Guardian Name(s): ____

Billing Address: ________________________________ City ___________________ State________________

Child lives with both parents? Yes____ No ____ If no, with whom does the child live?_________________

Primary language spoken in home: ____________________ Other language(s): ______________________

Pediatrician: _____________________________ Pediatrician Phone: _________________________________

How did you hear about me?________________________________

Previous speech therapy evaluations/treatment (list): ____

Describe present problem:

____

____

____

____

____

____

Who noted present problem? _______________________________When? ___________________________

What is your child's reaction to the problem? ____

____

How does the child's family react to the problem? ____

____

Has there been any significant change in last six months? _____ If so, what? __________________________

____

____

How well is your child understood? (i.e., approximately what percentage of the time?)

Parents:_________ Siblings: _________ Other children: ______ Extended family: _________

Unfamiliar adults: _______

PRENATAL/BIRTH HISTORY

Full Term: Yes_______ No_________ If no, how many weeks? __________________

Birth Hospital/Location: _____________________________ State:________________________

Illnesses or accidents during pregnancy: ____

____

Use of alcohol, tobacco or medications during pregnancy: ____

____

Birth weight: ________ Delivery: Vaginal_____ Cesarean_____

Breech (Feet First)_______ Head First______ Respiratory Issues at birth:___________________________

Other unusual conditions that may have affected pregnancy or birth? _______________________________

____

MEDICAL HISTORY/CURRENT HEALTH

Please check if your child has had any of the following (and if so, at what age):

Seizures ________	High fevers________	Measles________	Mumps ________
Chicken pox_______	Croup _______	Pneumonia________	Tonsillitis________
Meningitis________	Encephalitis________	Rheumatic fever _____	Tuberculosis_______
Asthma______	Sinusitis_______	Chronic colds _______	Enlarged glands________
Thyroid______	Heart trouble_________	Whooping cough _________	

Explain any checked items here: ____

____

Are immunizations current? Yes_______ No________

Has your child had any earaches/ear infections? Yes_____ No______ Eustachian tubes?_____

If chronic, please explain frequency here:

____

Allergies? Yes______ No_______ If Yes, describe____

____

Any other serious or recurrent illnesses? ____

Any operations? Yes ____ No______ If yes, please describe____

____

Any accidents/falls involving trauma to the head?

____

Any medications? If Yes, please list along with dosage and # per day (a preprinted list is also acceptable)

____

Vision problems? Yes _______ No______ If Yes, Past_______ Current_____

Please describe:____

Hearing difficulties: Yes_______ No_______ Dental problems? Yes_____ No________ If Yes, please explain____

Date of last hearing screening: ______________________________

Other Medical History not listed above: ____

____

DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed): sat up alone _______ crawled________ walked_______

toilet trained ______ dressed independently_______ tied shoes _______

Is the child left or right handed? ________________________

Attention span-for self-directed activities: ____________________ Adult-directed: ___________________

Bedtime: __________________ Does your child sleep well?_______________________________________

Does your child respond typically to: Light? ____________ Sound? __________ People? _______________

Cry appropriately? _______ Laugh? _______ Smile? _______

Get upset easily? _______ Have difficulty calming? _______

Have difficulty sitting still? _______ Have eating issues? _______

Have attention issues? _______ Have difficulty transitioning from one activity to another? _______

Perseverate (gets "stuck") on objects or activities? _______

Have complicated routines for bed, bath, mealtime, etc. _______

Cover his/her ears in response to otherwise typical sounds/noises? _______

Have difficulty with daily living activities (tooth brushing, hair washing, etc.) ________

Dislike having their hands dirty? _______

Does your child exhibit unusual behavior (explain)? ____

LANGUAGE DEVELOPMENT

Age when your child spoke first word: _________combined words: _________spoke in sentences: _______

What was your child's first word(s)? ____

First sentence? ____

Which sounds (if any) are of concern? ____

How many words can your child say? ______ (List if fewer than fifteen)______________________________

____

How many words are your child's sentences? ___________

Does your child have any difficulty understanding you?_____ If yes, please describe:

____

____

Does your child have difficulty following directions?______ (Describe) ________________________________

____

Any speech/hearing/learning problems in the immediate or extended family (explain)?

____

SOCIAL DEVELOPMENT

Names and ages of siblings: ____

Other adults living in the home: ____

Moves prior to age 10: ______________Relationship/s with peers: _____________________________

Number of regular playmates: ________________ Ages: _____________________ Genders: _____________

Activities shared with parents and siblings: ____

How does your child handle frustration?: ____

Conflict?: ____

Separation?: ____

Regular responsibilities?: ____

Favorite places?: ____

How many minutes/hours of television does your child watch per day?________Electronics?__________

What motivates your child most? ____

What discipline methods work best? ____

SCHOOL HISTORY

Child's Current School:____ Grade: ______________________

Child's performance educationally: ____

Receiving special services at school: Yes_______ No__________ If Yes, what services?_________________

____

Does your child currently have an IFSP, IEP or 504 plan?___________________________________

How does your child's teacher describe his/her performance? _______________________________

Has the teacher expressed any concern? Yes______ No_____ If so, explain: __________________________

____

What do you hope to have happen as a result of this evaluation? ________________________________

____

Anything else you would like us to know? ____

CONTACT INFORMATION

At times, I may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: ***ONLY Home address, one phone number and one e-mail address are required. Please report primary contact only.***

Primary Person Bringing Child: ______________________________

Primary Contact name:_____________________________________

Home Phone: __________________ Ok to leave message: Yes______ No_______

Cell Phone: __________________ Ok to leave message: Yes______ No_______

Email: ____________________________ Ok to Email Messages: Yes____ No_______

Please list anyone else who may be bringing the client and their relation:

1.____ 3. _______________________________________

2.____ 4. _______________________________________

Unless authorized in advance by parent/s or legal guardian/s, client information and therapy recap will only be provided to parent/s or legal guardian/s.

PARTY RESPONSIBLE FOR PAYMENT

Name: ____ DOB: ___________________ SSN: __________________

Address ____ Phone: _______________________________

Employer Name: _________________________________ Contact Phone: _______________________________

Company Address: ____

INSURANCE BILLING INFORMATION:

Primary Insured**:______________________________** DOB: **______________** SS#_________________________

Primary Insurance Carrier: ___________________________ Phone Number: _____________________________

Billing/Claim Address: _____________________________City: _____________________ State:______________

ID #: _________________________________ Group #: _______________________________

Secondary Insurance: ______________________________ Policyholder Name: __________________________

Phone Number: _____________________________ Billing/Claim Address: ______________________________

City:______________________________ State:_____________ ID#____________________________________

Group #: ___________________________________ ID Number: ___________________________________

Policy Group or Number: __________________________

NOTE: As a courtesy, I will verify your insurance benefits. However, due to inconsistent information provided by insurance companies, verification is not a guarantee of payment. Payment is ultimately the

responsibility of the patient/guarantor. If your insurance does not pay for services, it is YOUR responsibility to pay for services.

Assignment of Benefits (insurance patients only):

I_____________________________________, authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Simone Hüls, PhD of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder: ____ Date:______________

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): ________________________________ Date: _______________________

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Patient Signature (if over 18 years or emancipated):_____________________________ Date: _________

For minors- Legal Guardian Signature: ___________________________________ Date: ___________

Thanks so much for completing this form!