404-491-0710
speak2ispeak@gmail.com
ispeakspeechtherapy.com

Patient Information

Name:			
DOB: / /	Age:	☐ Male	☐ Female
Address:			
City:		State:	Zip:
Email:			
Phone:			
Person completing this form:			
Relationship to child:			
Mother's Name:			
Address:			
City:		State:	Zip:
Father's Name:			
Address:			
City:		State:	Zip:
Primary Care Physician's (PCP) Name:			
PCP Address:			
City:		State:	Zip:
Other doctors treating the child:			

How did you hear about us? ** Circle all the apply **

Referral	Doctor	Social Media	Cards/Marketing	Google	Other

List all children in the family from youngest to oldest.

Name	Age	Sex	Grade

Does anyone else in the family have speech/language concerns? Yes / No

Has the child had any previous testing or therapy for speech, language, or hearing problems? Yes / No

**If yes, name of agency and date tested:

Primary language spoken by child:	
Other languages spoken at home:	

Birth History

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Weight at Birth:		Was the child full term?	Yes No

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)? Yes / No

*** If yes, please describe:

Type of Birth:

** Circle all that apply **

Vaginal	Induced	Forceps	Caesarean	Premature
			How many weeks?	weeks

Were there any physical deformities or malformations observed at birth (such as "blueness,"jaundice, abnormal shape of head)? Yes / No

*** If yes, please describe:

Developmental History

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets?) yes / no

*** If yes, please describe:

Medical History

Has the child had allergies, hay fever, etc.? Yes / No
*** If yes, please describe:

Has the child had any operations? Yes / No
*** If yes, please describe:

Has the child had tonsils and adenoids removed? Yes/ No
** If yes, when?

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? Yes / No
*** If yes, please describe:

Has hearing been tested? Yes / No When? _________________

Has the child ever had ear tubes inserted? Yes / No When? _____________

Does the child have any dental problems? Yes / No
*** If yes, please describe:

Education HIstory

Current School:		
Address:		
City:	State:	Zip:
Grade:	Teacher:	

Does the child attend any special classes (such as speech therapy, language development,reading, resource room, special education classroom)? Yes / No
*** If yes, please describe:

Insurance Information

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Primary Insurance:	
Policy Holder Name:	
Group Number:	
Phone Number:	
Secondary Insurance:	
Policy Holder Name:	
Group Number:	
Phone Number:	

TREATMENT AUTHORIZATION

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I agree to allow iSpeak Speech Therapy to provide speech and language services for me or my child. In addition:

- ❏ I agree to attend scheduled therapy sessions (see attendance policy).
- ❏ I agree to participate in my child's/loved one's treatment, as appropriate.
- ❏ I understand that my child/loved one may be given work to do at home.
- ❏ I agree to help my child/loved one do this work to help with treatment goals.

Patient Printed Name ______________________ Date ______________

Patient or Parent/Guardian Signature ______________________ Relationship to patient ______________