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:_____

Pediatric Auditory Processing Form

Patient Name: _____
Last *First* *MI*

Date of Birth: ___/___/_____ Today's Date: ___/___/_____ Patient's preferred hand: ☐ Right ☐ Left
mo day year *mo day year*

Primary Care Physician: _____Referred by:_____

Primary Concern: _____

_____

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

_____

What school does the patient attend? _____Grade:_____

Prenatal and Birth History

Length of pregnancy:_____ Birthweight:_____

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

_____

YES	NO	
☐	☐	Remarkable pregnancy?
☐	☐	Maternal illness during pregnancy?
☐	☐	Complicated delivery?

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

After birth, did the patient have:

YES	NO		YES	NO	
☐	☐	Breathing difficulties?	☐	☐	Skin tags or pits near the ears?
☐	☐	Kidney problems?	☐	☐	Surgery?
☐	☐	Vision problems?	☐	☐	Jaundice (high bilirubin)?
☐	☐	Head, neck, or ear abnormalities?			If yes, did it require: Phototherapy or Transfusion
☐	☐	Head trauma or defect?	☐	☐	Diagnosis of neurologic condition
			☐	☐	Diagnosis or suspicion of a syndrome or other disorder?

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 _____

Family History

YES NO

☐ ☐ Does the patient have a family history of hearing loss before age 40?

☐ ☐ Does the patient have a family history of speech/ language/ communication/ learning disorders?

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

_____

Speech and Language History- General

YES NO

☐ ☐ Are there current concerns regarding speech and language?

☐ ☐ Has the patient received previous speech and language therapy?

If yes, please explain: _____
When did the patient receive services? _____
For how long did the patient receive services? _____

☐ ☐ Is more than one language spoken at home?

What languages are spoken at home?_____
What is the primary language spoken at home? _____

☐ ☐ Does the patient understand each language?

☐ ☐ Does the patient use each language?

At what age was the patient exposed to each language? _____

☐ ☐ Does the patient express frustration with communication?

Please elaborate: _____

Receptive Language

YES NO

☐ ☐ Do you have concerns about the patient's ability to follow directions or understand what others are saying to him/her? If yes, please elaborate: _____
_____

☐ ☐ Does the patient answer questions appropriately?

Expressive Language

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

YES	NO	
☐	☐	Think of the right words?
☐	☐	Use appropriate word order?
☐	☐	Use appropriate grammar?
☐	☐	Talk about events that will happen?
☐	☐	Talk about events that already happened?
☐	☐	Ask questions?
☐	☐	Participate in conversation?
☐	☐	Tell a story?
☐	☐	Express feelings and opinions?
☐	☐	Use specific words (versus overuse of words like "this", "over there", etc...)
☐	☐	Other: _____

Articulation and Pronunciation

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"): _____

_____

Behaviors and Characteristics

The following list has some common characteristics of auditory processing disorder.

Does the patient have difficulty:

- ☐ Listening in noisy environments?
- ☐ Understanding words?
- ☐ Spelling?
- ☐ Following verbal direction?
- ☐ Sarcasm and understanding jokes?
- ☐ Taking notes?
- ☐ Auditory fatigue?
- ☐ Playing instruments?
- ☐ Listening to the teacher, watching them, and writing at the same time?
- ☐ Telling the direction of sounds?
- ☐ Math, art, or music?
- ☐ New situations?
- ☐ Social situations and social skills?
- ☐ Interacting with other children?
- ☐ Comprehending someone's intent (nonverbal cues)?
- ☐ Hand and foot coordination?
- ☐ Interpreting the main idea of a spoken narrative?
- ☐ Associating visual symbols with sound (sound-letter correspondence)?

Hearing and Middle Ear History

YES NO

- ☐ ☐ Has the patient been seen by an Ear, Nose, and Throat physician?
  If yes, why, when, and by whom?_____
- ☐ ☐ Have the patient been seen by an audiologist for a hearing assessment?
  If yes, when and where? _____
  Were the results normal?_____
- ☐ ☐ Does the patient have any allergies?
- ☐ ☐ Does the patient have frequent colds or sinus infections?
- ☐ ☐ How many ear infections has the patient had? _____
  At what age were they resolved? _____
- ☐ ☐ Did the patient have P.E. tubes placed?
  If yes, when and by whom? _____
- ☐ ☐ Has the patient had ear problems in the past six months?
- ☐ ☐ Has the patient had ear pain?
- ☐ ☐ Does the patient have any history of problems chewing, feeding, swallowing, or drooling?
- ☐ ☐ Do you have any concerns about the patient's nutrition?
  If yes, please describe: _____

Physical Health

YES NO

- ☐ ☐ Is the patient taking any medications?
  If yes, please list:_____
- ☐ ☐ Has the patient had any surgeries?
- ☐ ☐ Has the patient had any illnesses?
- ☐ ☐ Has the patient had any injuries?
- ☐ ☐ How is the overall physical health of the patient?
  Explain:_____

Cognition

YES NO

- ☐ ☐ Are there concerns about the patient's cognitive ability?
  If yes, please explain:_____
- ☐ ☐ Has the patient received a cognitive assessment (WISC IV, etc.) by a psychologist?
  If yes, please bring a copy of this report to your evaluation appointment*
  When was the assessment completed? _____
- ☐ ☐ Was the patient diagnosed with a disorder?
  If yes, please explain:_____
- ☐ ☐ Has the patient followed through with the recommendations made by the psychologist?
  If yes, for how long?_____
- ☐ ☐ Has the patient made progess?
  If yes, please describe:_____

Attention

YES NO

☐ ☐ Are there concerns about the patient's attention and ability to focus?
If yes, please explain: _____

☐ ☐ Has the patient been evaluated for attention?
If yes, please bring a copy of this report to your evaluation appointment*
When was the assessment completed? _____
Where was the assessment completed? _____

☐ ☐ Was the patient diagnosed with an attention disorder?
If yes, please explain:_____
What recommendations were made? _____

☐ ☐ Has the patient received management?
If yes, for how long?_____
If no, why? _____
What kind of management? _____

☐ ☐ Has the patient made progess?
If yes, please explain:_____

Fine and Gross Motor Ability and Sensory Integration

YES NO

☐ ☐ Are there concerns about the patient's fine and gross motor skills and/or sensory integration?
If yes, please explain: _____

☐ ☐ Has the patient been evaluated by an occupational and/or physical therapist?
If yes, please bring a copy of this report to your evaluation appointment*
When was the assessment completed? _____
Where was the assessment completed? _____

☐ ☐ Was the patient diagnosed with a disorder?
If yes, please explain:_____

☐ ☐ Has the patient received management?
If yes, for how long?_____
If no, why? _____
What kind of management? _____

☐ ☐ Has the patient made progess?
If yes, please explain:_____

Autism Spectrum Disorders

YES NO

☐ ☐ Are there concerns about autism spectrum disorder?
If yes, please explain: _____

☐ ☐ Has the patient been evaluated for autism spectrum disorder?
If yes, please bring a copy of this report to your evaluation appointment*
When was the assessment completed? _____
Where was the assessment completed? _____

☐ ☐ Was the patient diagnosed with a disorder?
If yes, please explain:_____

☐ ☐ Has the patient received management?
If yes, for how long?_____
If no, why? _____

Academic History

Does the patient have difficulty with any subjects at school? YES NO
If yes, please explain: _____
What are the patient's best subjects at school? _____

How long does it take your child to complete his/her homework assignments? _____

Does the patient's teacher(s) have concerns? YES NO
If yes, please explain: _____

What grades is the patient receiving? _____

Is the patient receiving extra services? YES NO
If yes, what kind of service?_____
For how long? _____
Where? _____
Is it helping? YES NO

Does the patient have an IEP/504 Plan? YES NO
If yes, please bring a copy of this report to your evaluation appointment*
Please describe: _____

Does the patient:

YES NO

☐ ☐ Do better with math, art, and music?
☐ ☐ Frequently ask for repetition?
☐ ☐ Do better with concrete versus abstract ideas?
☐ ☐ Reverse words, letters, or numbers?
☐ ☐ Speak with flat or monotone speech?
☐ ☐ Need more time to process information and complete work?
☐ ☐ Do better understanding verbal information with visual cues?

Vision and Visual Processing

YES NO

☐ ☐ Are there concerns about the patient's vision and/or visual processing?
If yes, please explain: _____

☐ ☐ Has the patient been evaluated for a vision problem and/or visual processing?
If yes, please bring a copy of this report to your evaluation appointment*
When was the assessment completed? _____
Where was the assessment completed? _____

☐ ☐ Was the patient diagnosed with a disorder?
If yes, please explain:_____

☐ ☐ Has the patient received management?
If yes, for how long?_____
If no, why? _____
What kind of management? _____

☐ ☐ Has the patient made progess?
If yes, please explain:_____

Social Development

What extracurricular activites does the patient participate in? _____

Is the patient experiencing any difficulties with interacting with:

YES NO

☐ ☐ Other adults?
☐ ☐ Other children?

If yes, please elaborate: _____

In new situations, the patient:

YES NO

☐ ☐ Adapts quickly? Quickly warms up?
☐ ☐ Is shy? Is slow to warm up?
☐ ☐ Demonstrates anxiety?
☐ ☐ Has limited or no participation?

Other? _____

Other Developmental Delays?

Does the patient have any other developmental delays? YES NO

If yes, please explain: _____

Scale of Auditory Behaviors*

Please rate each item by checking the number that best fits the behavior of the child you are rating. The numbers correspond to the frequency with which the behavior is observed. Please consider these items carefully when rating each possible behavior. A child may or may not display one or more of these behaviors. A high rating in one or more of the areas does not indicate any particular pattern. If you are undecided about a particular item, use your best judgment.

Date: _____ Completed By: _____

Frequent	Often	Sometimes	Seldom	Never	Items
1	2	3	4	5	Difficulty hearing or understanding in background noise.
1	2	3	4	5	Misunderstands, especially with rapid or muffled speech.
1	2	3	4	5	Difficulty following spoken instructions.
1	2	3	4	5	Difficulty discriminating and identifying speech sounds.
1	2	3	4	5	Inconsistent responses to auditory information.
1	2	3	4	5	Poor listening skills.
1	2	3	4	5	Asks for things to be repeated.
1	2	3	4	5	Easily distracted.
1	2	3	4	5	Learning or academic difficulties.
1	2	3	4	5	Short attention span.
1	2	3	4	5	Daydreams, inattentive.
1	2	3	4	5	Disorganized.

Score (Clinician Use): ☐

(For Adult & Ped. APD)
*SAB (Conlin, 2003, Schow et al. 2006, Shiffman, 1999: Simpson, 1981, Summers, 2003)
Adapted from the MAPA Assessment Manual

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
- ❑ Mental Syndrome
- ❑ 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.

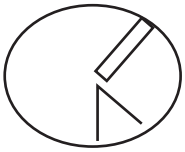
_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

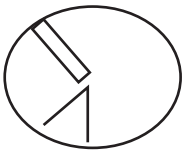
Kirkland Office • 12333 NE 130th Lane, #430 • Kirkland, WA 98034 • 425.899.5050 Fax - 425.899.5054
Bellevue Office • 1800 116th Ave NE, #103 • Bellevue, WA 98004 • 425.454.1883 Fax - 425.454.2036
Redmond Office • 8301 161st Ave NE, #208 • Redmond, WA 98052 • 425.882.4347 Fax - 425.882.0043

FOR AUDIOLOGIST'S USE ONLY

Otoscopic Inspection



RIGHT EAR



LEFT EAR

Active drainage observed	☐ YES	☐ NO
Visible Congenital or traumatic deformity	☐ YES	☐ NO
Visible evidence of significant cerumen	☐ YES	☐ NO
Air-bone gap of 15dB (.5, 1, or 2KHz)	☐ YES	☐ NO

Other pertinent information:

Summary:

Recommendations:

Medical Clearance: _____

Rescission Rights: _____

Physician Letter: Dr. _____

Hearing Instruments Initiated: _____

Additional Notes:

Audiologist Signature: _____ Reviewed:_____

For Speech Pathologist's use only. Areas assessed:

☐ Speech	☐ Language	☐ Literacy	☐ Cognitive-Linguistics
☐ Oral mechanism	- Receptive	- Reading	☐ Fluency
	- Expressive	- Writing	☐ Voice