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

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 Hearing Health History

Patient Name: _____ Gender: M F Age: _____ BD: _____ Date: _____

Person Completing Form: _____ Relationship to Patient: _____

I. Primary Concern: Please check **Yes** or **No** and describe below.

Do you feel this child has a hearing loss? _____ ❑ Yes ❑ No

Are you concerned about this child's speech or language development? _____ ❑ Yes ❑ No

Please Describe Concern: _____

_____

_____

II. Prenatal and Birth History:

Length of Pregnancy: _____ Birthweight: _____ APGAR Score: _____

List any medications or drugs (including alcohol) used during pregnancy. _____

_____

Please answer Yes or No for the following, and give details if Yes:

Remarkable Pregnancy _____ ❑ Yes ❑ No

Mother's illness during pregnancy (Herpes, Toxoplasmosis, CMV, Syphilis, Rubella)? _____ ❑ Yes ❑ No

Complicated delivery? _____ ❑ Yes ❑ No

After birth, did this child have:

Breathing difficulties (mechanical ventilation/ECMO)? _____ ❑ Yes ❑ No

Admission to the Intensive Care Unit? _____ ❑ Yes ❑ No

Head, neck or ear abnormalities? _____ ❑ Yes ❑ No

Skin tags or pits near the ears? _____ ❑ Yes ❑ No

Jaundice (high bilirubin)? _____ ❑ Yes ❑ No

Head trauma/defect? _____ ❑ Yes ❑ No

Surgery? _____ ❑ Yes ❑ No

Diagnosis of a neurologic condition? _____ ❑ Yes ❑ No

Diagnosis or suspicion of a syndrome or other unifying disorder? _____ ❑ Yes ❑ No

Vision problems? _____ ❑ Yes ❑ No

Kidney problems? _____ ❑ Yes ❑ No

Details: _____

_____

III. Family History: Please check **Yes** or **No** and describe below.

Family hearing loss before age 40? _____ ❑ Yes ❑ No

Please describe: _____

_____

IV. Communication and Developmental History: Please check **Yes** or **No** and describe below.

Difficulties with pronunciation? _____ ❑ Yes ❑ No

Language development concerns? _____ ❑ Yes ❑ No

Difficulties listening or understanding conversation? _____ ❑ Yes ❑ No

Attention problems at school (if applicable)? _____ ❑ Yes ❑ No

Other developmental delays? _____ ❑ Yes ❑ No

Please describe: _____

_____

V. Hearing and Middle Ear History: Please check **Yes** or **No** and describe below.

Previous hearing test? _____ ❑ Yes ❑ No

Allergies? _____ ❑ Yes ❑ No

Hazardous noise exposures? _____ ❑ Yes ❑ No

Noises in the ears (tinnitus)? _____ ❑ Yes ❑ No

Balance or coordination difficulties? _____ ❑ Yes ❑ No

Please describe: _____

_____

Middle ear health:

Number of ear infections: _____ At what age resolved? _____

P.E. Tubes Placed? _____ ❑ Yes ❑ No

If yes, (by whom and when placed): _____

History of ear pain? _____ ❑ Yes ❑ No

Please list any medications this child is currently taking: _____

General Observations:

Child responds to environmental sounds or voices? _____ ❑ Yes ❑ No

Child startles to loud noises? _____ ❑ Yes ❑ No

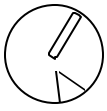
Child searches to find the source of sounds? _____ ❑ Yes ❑ No

VI. Physical/General Health Conditions:

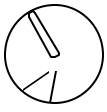
List any physical or health conditions or this child has. _____

For Audiologist's Use Only

Otoscopic



Right



Left

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

Other pertinent information:

_____ Audiologist

Summary

Recommendations

Patient Name: _____
Date of Birth: _____

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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 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
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