HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

Pediatric History Form

Child's Name_____ Today's Date _____

Date of Birth_____ Age _____ Gender _____

Person Filling out Form _____Relationship to Child _____

I. Describe any major concern(s) about your child: _____

_____

_____

_____

II. What specific questions would you like to have answered:

_____

_____

_____

III. Prenatal and Birth History:

1. During this pregnancy, did the mother experience any unusual illness, accident or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please describe: _____

_____

2. During the pregnancy did the mother (*please check)*

☐ Drink alcohol? ☐ Smoke?
☐ Take medication? ☐ Take recreational drugs?

Please describe:_____

3. Were there any complications with delivery? ☐ Yes ☐ No

Please describe: _____

Birth weight:_____How many weeks gestation at time of delivery: _____

4. Condition of baby at birth (bruised, jaundiced, difficulty breathing, etc.): _____

_____

Color good? ☐ Yes ☐ No Breathed easily? ☐ Yes ☐ No

Incubated? ☐ Yes ☐ No Spent time in NICU? ☐ Yes ☐ No

If yes, please describe length and reason of stay in Neonatal Intensive Care Unit (NICU): _____

_____

IV. Feeding History

1. Any feeding difficulties immediately after birth? ☐ Yes ☐ No

If yes, what kind?_____

My child was: ☐ Breast fed ☐ Bottle fed ☐ Both

2. Current feeding abilities (types of food/liquid and how often): _____

_____

Has your child ever gained/lost weight that was considered atypical? _____

Does your child need special spoons or cups? ☐ Yes ☐ No

My child has difficulty with (check all that apply): ☐ Chewing ☐ Swallowing

My child dislikes certain foods: ☐ Yes ☐ No Examples: _____

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V. Development

1. **At what age did the child:**

   Wean from breast: _____ Wean from bottle: _____ Stop using pacifier: _____
   Drink from sippy cup: _____ Drink from open cup: _____ Feed self: _____
   Sit independently: _____ First crawl: _____ Walk Independently: _____
   Stop thumb sucking: _____ Gain bowel control: _____
   Gain bladder control _____

2. **Describe your child's:**

   Overall development: _____
   Coordination and balance: _____
   Self-help skills (dressing, washing, etc.): _____
   Fine motor skills (using scissors, coloring, writing, etc.): _____
   Handedness: ☐ Right ☐ Left ☐ Undetermined ☐ Ambidextrous

VI. Medical History

1. **General**

   Does your child have frequent colds? ☐ Yes ☐ No
   History of fevers? ☐ Yes ☐ No
   History of seasonal allergies? ☐ Yes ☐ No
   History of ear infections? ☐ Yes ☐ No
   Most recent ear infection: _____ How was it treated? _____
   Other medical conditions or diagnoses: _____
   _____
   Is the child in good health at this time? ☐ Yes ☐ No, Explain: _____
   When was your child's most recent physical examination? _____
   Physician: _____ Clinic/Hospital: _____
   Current medications: _____
   Please list all allergies: _____
   Please list all illnesses, accidents, and operations:

DATE	AGE	TYPE	DURATION	SEVERITY	HOSPITAL

2. **Hearing**

   Does the child have a suspected or known hearing loss? ☐ Yes ☐ No
   Does anyone in the child's biological family have a hearing loss? ☐ Yes ☐ No
   Please list: _____
   Has your child had a hearing test before? ☐ Yes ☐ No
   If yes, where? _____ When? _____
   What were the results? _____
   Does your child wear hearing aids? ☐ Yes ☐ No If yes, for how long? _____
   Has your child seen a physician for an ear examination? ☐ Yes ☐ No
   When? _____ Results: _____
   Physician: _____ Clinic/Hospital: _____

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VII. Social/Education History

1. Social History

My child prefers to play (check all that apply):

☐ Alone ☐ With Others ☐ With Adults
☐ With Older Children ☐ With Younger children

Does your child have tantrums frequently? ☐ Yes ☐ No If so, how often?_____

What are some of your child's favorite activities?_____

What types of activities/interactions does your child least enjoy?_____

How would you describe your child's personality?_____

2. Educational History

My child is now enrolled in (check all that apply):

☐ School ☐ Preschool ☐ Daycare ☐ None

Name of Daycare:_____Hours and days per week:_____

Name of School/Preschool: _____District: _____

Teacher's Name: _____Grade: _____

Speech Pathologist: _____

Strengths in school: _____

Areas of difficulty: _____

Special therapies or services in school:_____

VIII. Speech/Language

1. History

Do you have any family history of speech/language delays or disorders? ☐ Yes ☐ No

If yes, please specify: _____

At what age did your child do the following?

Begin to babble:_____Say first word: _____

Put words together:_____Use short sentences: _____

Examples: _____

_____

2. Current Speech/Language Abilities

Can you usually understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Can others understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Is your child aware of her/his speech difference? ☐ Yes ☐ No

Does your child:

Readily imitate sounds, words, and/or sentences you say?

Respond to her/his name? ☐ Yes ☐ No

Point to pictures that you name? ☐ Yes ☐ No

Follow directions? ☐ Yes ☐ No

Ask/answer questions? ☐ Yes ☐ No

Relate events to you? ☐ Yes ☐ No

Understand more than s/he says? ☐ Yes ☐ No

Appear frustrated if s/he is not understood? ☐ Yes ☐ No

If yes, how is this frustration expressed? _____

Use sign language or other gestures to communicate? ☐ Yes ☐ No ☐ Sometimes

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3. **Stuttering**

Does your child stutter? ☐ Yes ☐ No ☐ Sometimes

Types of stuttering (*check all that apply)*:

☐ Whole word repetitions ☐ Syllable repetitions ☐ Sound repetitions

☐ Sound prolongations ☐ Total blocking

How long has this been occurring? _____

4. **Voice**

Does your child frequently have a hoarse voice or lose her/his voice? ☐ Yes ☐ No

5. **Other Therapy Services**

Please list all current and previous services, including evaluations, and therapy sessions. Example: Speech pathology, physical therapist. *Please provide name, address, and date*

Dates	Age	Service Type (Speech, OT, PT):	Provider:	Location:

6. **Please list any other speech/language concerns, or any information you feel is important for us to know**: _____

_____

IX. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

_____

_____

_____

_____

_____

X. Emergency Contact:

Name: _____ Relationship: _____

Email: _____ Phone: _____

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Medications List

Name: _____ Date of Birth: _____

Medications current as of: _____ _____ _____

_____ _____ _____

Please list all medications and dosages that you are currently taking. This information is confidential and will be kept in your client file. Should you need to make any changes to the form, you are welcome to do so in-person or over the phone at 206.323.5770.

This list must be reviewed at each diagnostic hearing test.

MEDICATION NAME	DOSAGES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Authorization for Use/Disclosure of Protected Health Information

Client Name: _____ **Birthdate:** _____

Release of Protected Health Information

My protected health information may be disclosed to the following:

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Signature required for release/obtain/exchange for information. **I understand that by signing below:**

- I authorize HSDC to release protected health information to the parties listed above.
- I authorize HSDC to release any information required to insurance companies, medical providers, and other as required by law or court order.
- I understand that in order to revoke these rights, a written notification must be submitted to HSDC.
- Authorizing the disclosure of health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.

_____ _____

Signed name of patient/personal representative Date

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_____

Printed name of patient/personal representative

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Hearing, Speech & Deaf Center (HSDC) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

Our Medical Insurance & Private Pay Policy

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

- Private pay patients –Full payment amount due at the start of the appointment.
- Inform HSDC of the current address and phone number for the Patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the start of the visit.
- When HSDC receives an explanation of benefits (EOB) from your insurance company, any charges for example: Non-covered service or Deductible, Co-insurance will be billed to you.
- Pay any additional amount owing within 15 days of receiving a statement from our office.

Attendance and Cancellation Policy

All appointments must be cancelled with at least 24 hours' notice.

- A missed appointment/no show fee of up to $75.00 may be charged for all appointments that are not cancelled with 24 hours' notice. Except in the case of emergency or illness,
- Patients who are more than 15 minutes late to an appointment will be marked as a "no-show" and will need to reschedule.
- If a client misses more than 20% of their appointments, they may be placed on "Walk-in" only status, meaning that they will not be given a routine time for scheduled appointments.
- If ongoing attendance is poor or problematic, services may be terminated.

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the patient's Responsible Party will be responsible for the original check amount in addition to a $ 25.00 Service Charge. Once notice is received of the returned check, HSDC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance—in addition to the $25.00 check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that HSDC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 50%, all court costs and attorney fees, and a collection fee added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name _____

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Patient Signature _____Date_____

Responsible Party Name _____

Responsible Party Signature_____ Date_____

Privacy Policy Agreement & Acknowledgement of Privacy Practices

Hearing, Speech & Deaf Center ("HSDC") wants you to be aware of the federal government rules and regulations that are in place to protect your health information. HSDC is committed to helping you understand these rules and regulations so that we can most effectively treat you and inform you how information that may identify you and that relates to your health care will be used. Some of these documents must be signed to show you received and understand them.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is a document that goes into detail to fully inform you about how your health information is used. The Notice of Privacy Practices covers the following topics:

- How HSDC manages and protects your health information
- How you can restrict certain uses and disclosures of your protected health information
- Your rights in requesting information about your protected health information; and
- Contact information if you have any questions or concerns regarding your protected health information.

You are requested to sign this acknowledgment that you received the Notice of Privacy Practices.

Acknowledgment of receipt of Notice of Privacy Practices

By signing below, I acknowledge that I received a copy of Hearing, Speech & Deaf Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available.

Printed name of patient/personal representative

_____ _____

Signed name of patient/personal representative Date

_____