Shoreline
Speech & Language Center

2200 Pacific Coast Hwy, Ste 210
Hermosa Beach, CA 90254
T: (310) 740-9493
F: (310) 469-7848
info@shorelinespeech.com

Intake Form

Patient's Name _____ DOB _____ Sex _____
Home Address _____ City/State/Zip _____
Home Phone _____
Current School _____ Grade _____
Pediatrician/Family Dr. _____ Phone _____

Father _____ Age _____
Email _____ Cell _____
Employer _____ Occupation _____
Address _____ Business Phone _____

Mother _____ Age _____
Email _____ Cell _____
Employer _____ Occupation _____
Address _____ Business Phone _____

Other Caregiver/Nanny _____ Cell _____

Name of Insured _____ I.D. # _____

Referred by _____ Phone _____
Reason for Referral _____

Is there a positive history for the following?
_____ ear infections
_____ tubes (myringotomies)
_____ adenoidectomy
_____ attention deficit
_____ other (explain) _____

Date: _____ Signature _____

FOR OFFICE USE ONLY
Diagnosis _____
Additional Information _____
Evaluation _____ Therapy _____ Therapist _____

Case History Form

General Information:

Name of Patient: _____

Mother's Name: _____ Father's Name: _____

Diagnosis (if any): _____

School: _____ Teacher: _____ Tel #: _____

Primary Physician: _____ Tel #: _____

Child's primary language: _____ Other languages: _____

Referred by: _____

Medical History:

Hearing Tested? Y N When? _____ Results? _____

Ear Infections? Y N

a. Frequency: _____
b. Treatment: _____
c. Tubes Y N
d. Did it affect their speech/communication? _____

Vision Tested? Y N When? _____ Results? _____

a. Acuity: _____
b. Perceptual: _____

Any Medications? Y N For what? _____

Type (s): _____ When began? _____

Describe how medication affects child's behavior, alertness, etc. _____

_____

Are there any dietary restrictions? _____

Allergies: _____

Allergist: _____ Tel #: _____

Age (s) _____ Reason: _____

Ears, Nose, Throat Specialist:_____Tel #:_____
Age (s) _____Reason:_____

Developmental Pediatrician:_____Tel #:_____
Age (s) _____Reason:_____

Neuropsychologist:_____Tel #:_____
Age (s) _____Reason:_____

Orthodontist:_____Tel #:_____
Age (s) _____Reason:_____
Treatment:_____

Ophthalmologist:_____Tel #:_____
Age (s) _____Reason:_____

Developmental Optometrist:_____Tel #:_____
Age (s) _____Reason:_____

Has your child had any of the following? (serious illness, surgeries, hospitalizations, seizures, etc.) Y N

_____
_____
_____
_____
_____

Developmental History:

Describe pregnancy and birth of your child (health, premature, difficulties)

_____
_____
_____
_____
_____
_____

Does your child:

Use a pacifier	Y N	Age Stopped	_____
Use a bottle	Y N	Age Stopped	_____
Suck thumb/fingers	Y N	Age Stopped	_____

At what age did your child:
Sit unsupported_____ Walk_____ Drink from an open cup_____
Babble_____ Say first word with meaning _____
Use single words_____ Use combined words _____
Use sentences_____Tell stories_____
Ask questions_____Answer questions_____
Follow directions_____

Obtain bladder control Y N Day_____ Night_____
Obtain bowel control Y N Day_____ Night_____

What are your child's eating habits? _____
_____
_____

How does your child interact with siblings, other children, and adults? _____
_____
_____

How does your child react to new situations? _____
_____
_____
_____

What does your child like or dislike? _____
_____
_____

Additional activities your child participates in (music, sports, etc.): _____
_____
_____

What words would you use to describe your child?_____
_____
_____
_____

Therapy History:

Speech Therapist: _____ Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Physical Therapist: _____ Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Occupational Therapist: _____Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Psychologist/Psychiatrist: _____Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Social Group: _____ Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Educational Therapist: _____Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Behavioral Therapist: _____Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____
Additional Comments:_____

Vision Therapist: _____ Tel # _____
Age(s) _____ Length of Therapy:_____Therapy completed: Y / N
Response to Treatment:_____

Additional Comments:_____

Family Information:

Who does the child live with? _____

_____

Siblings, names, and ages: _____

_____

_____

Is there a family history of communication/neurological or other difficulties? If yes, describe: _____

_____

_____

_____

Educational History:

Where does your child attend school? _____

Tel # _____ How long at this school?_____ Grade:____

Teacher's Name: _____

Previous schools? _____

What kind of difficulties is your child experiencing at school regarding learning, language, speech…? _____

_____

_____

_____

What, if any, difficulty does your child experience at school regarding socialization?

_____

_____

_____

_____

When was your child's problem noticed at school and what was done to facilitate him/her? _____

_____

_____

_____

Speech and Language Information:

What do you feel is the problem? _____

Please circle Y (yes) / N (no) to identify possible difficulties experienced by the child. Explain details as best you can.

Difficulty expressing self? Y N, if yes, explain: _____

Difficulty understanding language? Y N, if yes, explain: _____

Speech is unclear? Y N, if yes, explain: _____

Difficulty with memory? Y N, if yes, describe: _____

Difficulty with attention? Y N, if yes, describe: _____

Difficulty with organizing thoughts? Y N, if yes, describe: _____

Difficulty with feeding skills? Y N, if yes, describe: _____

Difficulty swallowing? Y N, if yes, describe: _____

_____

_____

Any other difficulties not mentioned? _____

_____

Other comments or concerns? _____

_____

_____

Person completing form:_____

Relationship to client:_____

Signed:_____Date:_____

Thank you!

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RELEASE OF INFORMATION

I, _____, _____, hereby give consent to the therapists
Your name relationship to child

at Shoreline Speech & Language Center to release information concerning the evaluation,

treatment and care of _____ D.O.B. _____.
minor's name

to _____
Physician's name
_____
Physician's address
_____
Physician's phone number

to _____
name
_____
profession
_____
email phone

to _____
name
_____
profession
_____
email phone

_____
Signature of Parent, Guardian, or Authorized Agent Date

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PRIVACY NOTICE AND CONSENT FORM

Keeping client information confidential and secure, and using it only as our clients would want us to, is a top priority. Here, then, is our promise to our clients and their families:

1. We will safeguard, according to strict standards of confidentiality and security, any information that clients share with us. What is discussed as part of the therapy process is confidential unless and until you give consent to its release.
2. We will permit only authorized employees, students, and instructional staff who are trained in the proper handling of client information to have access to that information.
3. We will not reveal client information to any external organization unless we have previously informed the client in disclosures or agreements, have been authorized by the client to share the information, or are required by law to reveal that information.
4. We will always maintain control over the confidentiality of our client information.

In short, any personal information that we collect about you or your family will be protected by physical, electronic, and procedural safeguards that meet or exceed applicable law. Finally, information obtained from clients, which includes video, may be used for educational and research purposes. If this occurs, information will be handled professionally, treated confidentially, and any identifying information about the client is removed.

I have read the above policy statements and agree to these conditions.

_____
Signature of Client/Guardian

_____ _____
Print Client's Name Date

_____
Shoreline Partner

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SHORELINE POLICIES AND PROCEDURES

- Individual therapy sessions are $170.00 per 50 minute session.
- Group sessions are $100 per child.
- Evaluation sessions are $200.00 per 50 minute session.
- Comprehensive evaluation report is $200.
- Appointments must be canceled by 7:00 am the morning of the appointment.
- Failed appointments and cancellations after 7:00 am the morning of the appointments will be billed at the regular rate.
- Request progress reports for medical evaluations or school IEP meetings at the earliest possible advanced notice.
- Provide the earliest possible advanced notice for scheduling our attendance at IEP meetings.
- IEP, school visits and parent conferences are charged at the therapy session rate.
- Additional paper work required for insurance billing is charged at $45/per hr.

Speech pathology services are provided for the parent with the understanding that payment for such services is the responsibility of the patient, parent, or guardian. Payment is expected at the time of service or end of the therapy week unless otherwise arranged. Shoreline does not accept direct insurance billing but will assist you in gaining the benefits due you. We express or make no implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you.

Billable charges are as follows:

Therapy sessions
Failed appointments and cancellations after 7:00 am the morning of
Parent Conferences
School visits
IEP meetings
Team meetings
Reports

I have read and agree to these policies.

Signed:_____Date:_____

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INFORMED CONSENT FOR USE OF THERAPY EQUIPMENT

I understand that my child, _____, will be involved in therapeutic activities which may involve the use of specialized equipment such as suspended equipment and various swings, large therapy balls, trampolines, spinning chairs, tactile or touch media, and fine motor, oral and eye-hand coordination activities I have been informed by the staff of Shoreline Speech & Language Center regarding the nature of, as well as the risks associated with the use of this equipment and these activities.

☐ **I give** consent for my child to engage in the use of therapy equipment and participate in therapeutic activities described above.

☐ **I do not give** consent for my child to engage in the use of therapy equipment and participate in therapeutic activities described above.

_____ _____

Signature of Parent or Guardian Date

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Office Directions

Address:

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Suite 210
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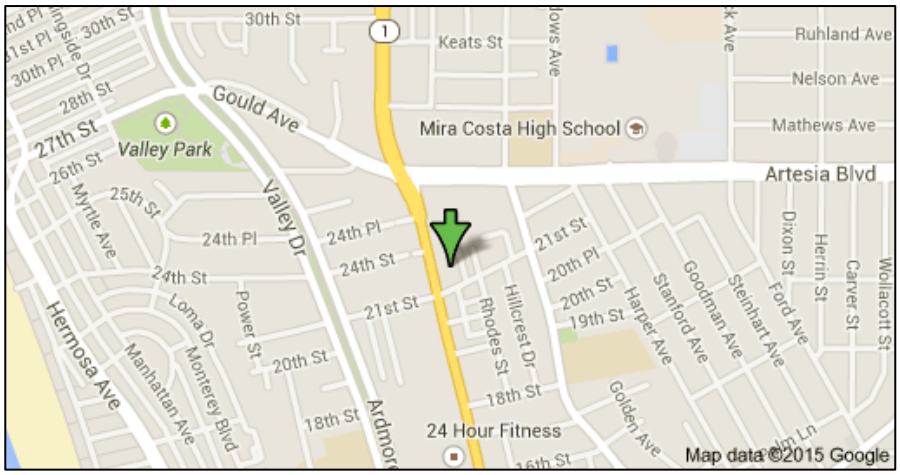
Major Cross Street: Artesia

*We are located toward the back of the building off of Borden Street.

Parking:

- Visitor parking is located off PCH in front of the building
- Street parking is available behind the building on Borden (& 21st St.)



Questions? Please call our office.

- Main line (310) 740-9493
- Maureen (310) 954-9740