The University of Georgia

SPEECH AND HEARING CLINIC
QUESTIONNAIRE FOR CHILDREN/ADOLESCENTS

Please complete this form as completely as possible. Attach copies of any additional information or reports that might assist us in our evaluation. Any information regarding your child will be handled in a confidential and secure manner.

IDENTIFICATION

Child's name: ______________________________ Birthdate: ____________ ☐ Male ☐ Female
First Middle Last

Address: ____
Street/PO Box City State

Zip Code: __________ County: ______________ Birth Country (if other than US): ________________

Primary Physician: ______________________________ Telephone: ______________

Mother's/Guardian's Name: ______________________________ Birthdate ______________

Address (if different): ______________________________

Telephone: Home ( )__________ Work ( )__________ Cell ( )__________ Fax ( )__________

Email: ______________________________ Last Grade Completed: ______________

Occupation: ______________________________ Employer: ______________

Father's/Guardian's Name: ______________________________ Birthdate: ______________

Address (if different): ______________________________

Telephone: Home ( )__________ Work ( )__________ Cell ( )__________ Fax ( )__________

Email: ______________________________ Last Grade Completed: ______________

Occupation: ______________________________ Employer: ______________

Emergency phone ( ) __________ Contact person: ______________________________
Relationship to Client

May we contact you about your appointment at the above addresses/telephone/email? ☐ Yes ☐ No. If no, please state where we may not contact you: ______________________________

Person or agency that referred you to our program: ______________________________

Reason for referral/concerns: ______________________________

____

What is your opinion of the cause for the concern? ______________________________

____

When was the concern first noticed? ______________________________

What has been done about it? ______________________________

Is your child aware of the concern/problem? ☐ No ☐ Yes: ______________________________

Name:_____________________ **Birthdate:** _____________________ **Date:** ________________

PREGNANCY AND BIRTH INFORMATION

Check any illnesses of the mother during pregnancy: □ Diabetes □ Gestational diabetes □ Hypertension □ Group B strep

□ Toxemia □ Other: ____

Were there any accidents or complications during pregnancy? (describe):____________________________

____

List medications taken during pregnancy and reason: ____________________________

Were alcohol, drugs, or tobacco used during pregnancy? □ No □ Yes. If so, please describe: ____________________

Was the child born before due date? □ No □ Yes Born after due date? □ No □ Yes. If yes, how many weeks early/late? _________

How long was labor? ______________________ Was delivery breeched? □ No □ Yes By C-section? □ No □ Yes

Birth weight: ____________________ Did the baby have any meconium (bowel movement) aspiration/staining? □ No □ Yes

Describe any unusual problems during the birth process: ____________________________

Did infant need oxygen? □ No □ Yes. If yes, how long? ________ Mechanical ventilation? □ No □ Yes. If yes, how long? ________

Was the baby placed in a Neonatal Intensive Care Unit? □ No □ Yes. If yes, how long? ____________________

Was he/she jaundiced (yellow) at birth? □ No □ Yes. If yes, was a blood transfusion required? □ No □ Yes

Describe any other problems noted after birth: ____________________________

Was baby released from the hospital with the mother? □ Yes □ No. If no, when did baby go home? ________________

Describe any health or feeding problems during the first few weeks of life: ____________________________

____

Did your child have problems within the first few months of life with □ Sucking? □ Swallowing? □ Choking? □ Chewing?

□ Breathing? If so, please describe: ____________________________

MEDICAL/HEALTH INFORMATION

List any limitations or precautions due to medical reasons: ____________________________

List any current medications (please attach list, if additional space is needed):

Medication	Dosage	Frequency	Route (Mouth/Injection/Patch, etc.)	Reason for Medication

Are there any allergies to: Medications (list): ____________________ Foods: □ Peanuts □ Other foods: ____________________
Check any environmental allergies: □ Dust □ Molds □ Pets □ Pollen □ Other: ____________________________

Has your child had any allergic reactions to any of the following:

Balloons?	□ Yes*	□ No	Surgery or dental work?	□ Yes*	□ No
Latex/rubber gloves?	□ Yes*	□ No	Other rubber or latex products?	□ Yes*	□ No

Does the child have Spina Bifida/Myelomeningocele? □ Yes* □ No

** Use non-latex products if "Yes"*

Name:____ **Birthdate:** ______________ ___________ **Date:** _______________

Describe any surgeries or hospitalizations your child has had:

☐ Adenoidectomy Date:	☐ Ear Tubes: Date Inserted - Right: Left:
☐ Tonsillectomy Date:	☐ Other:

Has your child had a hearing test? ☐ No ☐ Yes	If yes, when?	Where?	Results?
Has your child had a vision test? ☐ No ☐ Yes	If yes, when?	Where?	Results?

List other physicians your child sees:

Specialty	**Name (First, Last)**	**Address/Location**
Ears		
Eyes		

Please check and describe any conditions that apply to your child's medical history. Please state age and frequency, if applicable:

☐ Asthma	☐ Bleeding Disorders	☐ Breathing Problems
☐ Bronchitis	☐ Cancer Type:	☐ Cerebral Hemorrhage/Stroke
☐ Chicken Pox	☐ Cleft Lip	☐ Cleft Palate
☐ Colds (frequent)	☐ Concussion	☐ Convulsions/Seizures Type:
☐ Craniofacial Problems (describe):		
☐ Cytomegalovirus (CMV)	☐ Diabetes	☐ Diphtheria
☐ Dizziness/Vertigo	☐ Ear Infections (ages/frequency):	
☐ Encephalitis	☐ Head/Brain Injury (describe)	
☐ Headaches	☐ Heart Problems:	☐ Hepatitis Type:
☐ High Fevers	☐ HIV/AIDS	☐ Intestinal Problems
☐ Lupus	☐ Measles	☐ Meningitis
☐ Multiple Sclerosis	☐ Mumps	☐ Muscular Dystrophy
☐ Polio	☐ Pneumonia	☐ Rheumatic Fever
☐ Reflux/Heartburn	☐ Scarlet Fever	☐ Sickle Cell Anemia
☐ Sinus Infections	☐ Skin Problems: ☐ Dermatitis ☐ Eczema ☐ Other	
☐ Snoring	☐ Stomach Problems	
☐ Spina Bifida/Myelomeningocele	☐ Syndrome:	☐ Urinary Tract Problems (congenital)
☐ Vocal Polyps	☐ Vocal Nodules	☐ Voice: Hoarseness
☐ Voice / Resonance Problems - Describe:		☐ Whooping cough
☐ Other:		

Please provide any additional information to describe current problems or health concerns: ______________________________

____

Describe any dental or orthodontic problems: ____

Did/does your child wear braces? ☐ No ☐ Yes: ____

Did/does your child suck ☐ Thumb ☐ Finger(s) ☐ Pacifier? How frequently? ___________________________

If stopped, please describe frequency of sucking and age when stopped: _______________________________

Name:__________________________ **Birthdate:** ______________ **Date:** ____________

Does your child breathe with mouth open? ☐ No ☐ Yes: ☐ Day ☐ Night ________________________

Do liquids or food ever come through child's nose? ☐ No ☐ Yes: ________________________

Does your child avoid eating certain types or textures of foods? ☐ No ☐ Yes: ________________

Does your child choke or cough when eating or drinking? ☐ No ☐ Yes: ____________________

Describe any eating, feeding, or swallowing concerns or problems: ________________________

Describe any concerns about your child's growth: ____________________________________

DEVELOPMENTAL INFORMATION

Please describe any concerns about your child's speech, language, or hearing skills: ________________

____

As well as you can remember, list the age at which the following occurred:

Speech/Language/Hearing	Age
Babbled / cooed	
Turned to sound	
Responded to name when called	
Said first word (describe):	
Put two words together	
Used short sentences	
Learned to say the alphabet	
Understood rhyming/could rhyme words	

Motor/Behavior	Age
Crawled on all fours	
Sat alone unsupported	
Walked unaided	
Toilet trained while awake	
Toilet trained at night	
Fed self	
Gave up the bottle	
Drank from a cup alone	

Does your child understand/follow: ☐ Simple directions/commands? ☐ 2-step directions? ☐ 3-step directions?

How does your child make needs known? ☐ Speaking ☐ Grunting ☐ Pointing ☐ Gestures ☐ Other ____________

Did your child start babbling or talking then stop? ☐ No ☐ Yes: Please describe: ____________________

Check all that describe your child's current communication: ☐ Uses babbling (sound repetitions like baba, dada)

☐ Uses jargon (unrecognizable words that sound like speech) ☐ Uses words: ☐ 1-5 ☐ 5-10 ☐ 10-50 ☐ More than 100 words

☐ Uses 2-word phrases ☐ Uses 3 to 4-word phrases ☐ Uses complete sentences ☐ Uses conversation ☐ Initiates conversation

☐ Asks questions ☐ Retells simple stories ☐ Repeats nursery rhymes ☐ Answers questions appropriately

Does your child hesitate or repeat sounds or words when talking? ☐ No ☐ Yes: Please describe: ______________

List any sounds your child makes incorrectly: ____________________________________

As your child developed, were his/her speech, language, and motor skills similar to other children? ☐ Yes ☐ No

If no, please describe: ____

Does your child have difficulty learning new skills or playing new games? ________________________

What games, playground equipment, or activities does your child dislike? ________________________

What activities does your child enjoy (include games, sports, hobbies, toys, etc.)? ____________________

____

Name:____ **Birthdate:** ___________________________ **Date:** ________________

Please check all that apply to your child:

Can: ☐ Catch a ball ☐ Kick a ball ☐ Throw a ball ☐ Skip ☐ Hop ☐ Jump ☐ Balance on one foot ☐ Ride a tricycle or bicycle ☐ Dress independently (If not, what help does he/she need?)
Dislikes or is very sensitive to: ☐ Having hair/face/body washed ☐ Having teeth brushed ☐ Clothing tags ☐ Spinning ☐ Hearing loud noises ☐ Being hugged by a family member ☐ Change in activity or routine ☐ Other:
Has trouble with: ☐ Puzzles/manipulative toys ☐ Writing Describe:
Does frequently or seeks out: ☐ Rocking ☐ Twirling ☐ Jumping ☐ Biting ☐ Spinning ☐ Mouthing toys ☐ Repetitive activities ☐ Climbing ☐ Head banging
Appears to: ☐ Be insensitive to pain ☐ Be clumsy ☐ Be distracted by sounds ☐ Be distracted by lights ☐ Be easily frustrated ☐ Be aggressive ☐ Have difficulty concentrating
☐ Plays alone ☐ Gets along well with adults ☐ Plays well with other children his/her age. Age of playmates: ____________________ Please describe any problems with play or getting along with others:

Other than TV, how long can your child attend to a play activity? ____

How long can your child attend to a difficult task? ____

Is your child ☐ Right-handed? ☐ Left-handed? ☐ Not yet established (uses both hands)? ______________________________________

List any concerns you have about your child's motor, attention, or play skills: ____

Describe any discipline problems you have had with your child: ____

What is your child's usual behavior when he is angry or frustrated? ____

Does your child have any unusual fears? ☐ No ☐ Yes: Describe: ____

Are there any other social or emotional problems? ☐ No ☐ Yes: Describe: ____

FAMILY INFORMATION

Marital status of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Child currently lives with: ☐ Both parents ☐ Parent:_________________ ☐ Guardian ☐ Foster parent(s): _________________________

How has your child's problem affected your family? ____

What language(s) is/are spoken in the home? ☐ English ☐ Spanish ☐ Other: ____

If other than English, what language(s) does the child understand? __________________________ Speak? ___________________________

What is the dominant language used by the child? ____

List all people now living in the household, including brothers, sisters, other relatives, foster children, friends, etc.:

Name	Relationship to Child	Age

List any members of your immediate family with a history of speech, language, reading (dyslexia), motor, academic, psychological, or behavioral problems: ____

Please describe any problems listed for family members: ____

Does anyone in your family have hearing problems? ☐ No ☐ Yes: Describe: ____

Name:_________________________ Birthdate: _________________________ Date: ________________

EDUCATIONAL INFORMATION

Please list day care, preschool, and school experiences:

Name of School	Dates Attended	Grade/Placement

What kind of grades does your child receive? ______________________________

How does your child's teacher describe his/her performance? ______________________________

List any resource or special services received: ______________________________

Describe any problems your child has had in school: ______________________________

If your child is enrolled in special education, is there a current Individualized Educational Program (IEP)? ☐ No ☐ Yes: Describe current goals: ______________________________

If your child is enrolled in Babies Can't Wait, is there a current Individualized Family Service Plan (IFSP)? ☐ No ☐ Yes: Describe current goals: ______________________________

Please list any previous evaluations or therapy for speech, hearing, physical, occupational, psychological, or behavioral problems:

Date(s)	Type Service/Evaluation/Therapy	Agency	Location

Please have copies of previous evaluations sent to our Clinic before your evaluation appointment, if possible, or bring with you.

Please describe your child's strengths: ______________________________

Please add additional comments about your child that may be helpful in our evaluation: ______________________________

____

____

What are your expectations from this evaluation? ______________________________

____

____

Signature of Parent/Guardian Completing Questionnaire Relationship Date

The University of Georgia

THE UNIVERSITY OF GEORGIA
SPEECH AND HEARING CLINIC
PATIENT REGISTRATION FORM

Today's Date:	**Birthdate:**	**Sex**: ___M ___F ___ **Transgender-Other**	**Primary Care Physician:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle:**	**Marital status:**

Social Security #:	**Address:** **[Address/ P.O Box, City, ST ZIP Code]**

Ethnicity: ☐ **Asian** ☐ **Black/African American** ☐ **Caucasian/White** ☐ **Alaskan Native** ☐ **American Indian** ☐ **Hispanic/Latino**
☐ **Native Hawaiian or Other Pacific Islander** ☐ **Other** ____________ ☐ **Decline to provide**

Preferred Language: ____________ **Do you require an interpreter?** ☐ **No** ☐ **Yes Type:** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone**: ____________.

May we contact you at any of the above numbers and leave a message? ☐ **Yes** ☐ **No**

If no, Please let us know which numbers "NOT" to call: ____________

By providing this telephone number, I understand, agree and give express consent that the UGA Speech and Hearing Clinic or anyone working on their behalf, including third party vendors, may contact me at the number provided by manually dialing the number or by using automated dialing technology.

Please note the only third-party vendor who may contact you on our behalf is a collection agency, if necessary to collect payment.

How did you find out about us:	**Employer:**	**Employer phone no.:**
___Physician ___Friend ___Yellow Pages ___Internet ___ Advertisement ___Insurance ___ Other: ____________		

INSURANCE AND FINANCIAL RESPONSIBILITY INFORMATION

(Please have your insurance card available when you check in and give it to the receptionist.)

Person responsible for bill:	**Birthdate:**	**Address (if different):**	**Home/Cell/Work phone no.:**
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**

Name of Primary Insurance:

Subscriber's name:	**Subscriber's S.S. no.:**	**Birthdate:**	**Group no.:**	**Policy no.:**	**Co-payment:**

Patient's relationship to subscriber:

Name of Secondary Insurance (if applicable):	**Subscriber's name**	**Relationship to Patient**	**Group no.:**	**Policy no.:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**

Financial Policy

Please initial below to indicate that you have read and understand the Clinic's Financial Policies.
Discuss any concerns with the Clinic Accountant, Ms. Kathy Moss, at 706-542-3895.

Initials	
	Information: You agree to provide your correct name, current and correct address, phone numbers, insurance information, Social Security number, driver's license or state issued picture identification at the time of registration or as requested by the UGA Speech and Hearing Clinic. These are needed for verification of benefits and to reduce the possibility of identity fraud. These measures are taken to protect you.
	Appointments: Our office will make every attempt to schedule appointments that are convenient for you. Minors and patients requiring assistance must be accompanied by a parent/guardian or caregiver unless special arrangements have been made with the office. We require a minimum of a 24-hour notice for cancellations as a courtesy to other patients seeking services. We will bill $25.00 for appointments missed without a 24-hour notice (this amount cannot be billed to third-party payers). A pattern of missed appointments without notice may result in discharge from the clinic. (Continued on the reverse side)

Initials	
	Medical records: The medical chart is the property of the UGA Speech and Hearing Clinic; however, copies of your pertinent medical information are available upon request. The Clinic charges a fee for a copy of the record according to those published annually by the State of Georgia Comptroller's Office. This fee schedule is available upon request.
	Financial Responsibility: You are responsible for all charges related to services you have received in our clinic. When the patient is a minor or under guardianship, the parent or guardian accompanying the patient assumes the responsibility.
	Payment methods: We accept cash, checks, MASTERCARD, DISCOVER, VISA and AMERICAN EXPRESS credit cards. **Returned checks:** If your check is returned from the bank, you are responsible for all related fees with a minimum charge of $35.00.
	Insurance Claims: If applicable, our office will submit insurance claims. Insurance companies do not pay all fees and may exclude certain services and diagnosis form coverage. **It is your responsibility to understand your insurance plan.** Insurance payment is not guaranteed even if you have confirmation verbally or in writing from your carrier. An insurance company's response to a claim is the final decision in determining coverage. All copayments are due at the time services are received. All deductibles, coinsurance, or non-covered services are to be paid within 30 days of the first statement sent to the responsible party. If it is not possible for you to pay the complete balance within 30 days, please contact our office at 706-542-3895. We will help find the right payment option for your needs. Financial assistance is available for clients who apply and meet requirements. **Slow Insurance Response:** You understand that if your insurance company takes more than 60 days to respond to your claim, we shall consider your services to be your financial responsibility. It will be your responsibility to seek reimbursement from your insurance carrier. **Usual and customary**: Some insurance plans may indicate that our fees are above the *usual and customary*. As a result your plan may reduce our fee to an *allowed amount* before calculating payment. Unless we have specifically contracted with the carrier, it is expected that you will be responsible for the full fee charged**.**
	Statement Policy: Our office sends patient statements each month. Payment is due upon receipt of the statement. You understand that if we file an insurance claim for services, the sending of a statement may be delayed until your insurance responds. Such a delay should not take more than 60 days. You understand that such a delay does not alter our policy of patient financial responsibility, and you will be responsible for all service fees. I agree to pay the UGA Speech and Hearing Clinic for services received, in accordance with the rates and terms of the Clinic, including my portion of charges that were **1.** Not paid by insurance carriers, worker's compensation, or any third pary, and/or **2.** Not covered by adjusted fee or scholarships approved by the Clinic
	Collections policy: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge for their services. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33.3% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.
	Physician Referrals/Prescriptions: We must have an original prescription from a physician if the patient: 1. Is a Medicare or Medicaid recipient, when required for a covered service. 2. Has Medicare benefits and is referred by a physician for audiology testing to help the physician diagnose or manage the patient. (Note: Medicare does not cover testing to determine the need for or type of hearing aid) 3. Receives insurance benefits that require a referral/prescription for services to be reimbursed; or 4. Has a medical condition that our clinic policy requires a referral/prescription before services are provided. **"You will not be seen for your appointment if we do not have a written referral/prescription when required."**
	Medicare and Medicaid have restrictions on services provided by students; please request additional information if you are a beneficiary of either. We are required to give Medicare and Medicaid beneficiaries an Advanced Beneficiary Notice of Non-coverage (ABN) when we expect a denial or partial payment for an item or service.

☐ **I do not have health insurance coverage; therefore, I understand that I am responsible for payment to the UGA Speech and Hearing Clinic.**

Signature: ____________________ Date: ____________________

☐ **As provided for under the HITECH Act, I request that my medical information not be disclosed to my insurance carrier to file a claim for payment. I understand that I am responsible for payment in full to the UGA Speech & Hearing Clinic for the services I do not want disclosed. Services "not" to be disclosed include:** ____________________

(Discuss this request with our accountant)

Signature ____________________ Date ____________________

☐ **I authorize my insurance benefits be paid directly to the UGA Speech and Hearing Clinic. In the event your insurer sends a payment for a claim from the UGA Speech and Hearing Clinic directly to you, you agree to forward that payment to us in fulfillment of any amounts due. I understand that I am financially responsible for any balance.**

I authorize The UGA Speech and Hearing Clinic to release any information required to process my claims.

Signature: ____________________ Date: ____________________

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above. The above information is true to the best of my knowledge.

Signature: ____________________ Date: ____________________

THE UNIVERSITY OF GEORGIA
College *of* Education
The Speech and Hearing Clinic

UGA Speech and Hearing Clinic
Communication Sciences and Disorders Program
593 Aderhold Hall, Athens, GA 30602
706.542.4598

CONSENT FOR SPEECH AND HEARING CLINIC SERVICES

Client's Name: ____ **Client's DOB:** ________________________

Parent/Guardian's Name (if client is a minor): ____

I, ____, hereby authorize The University of Georgia Speech and Hearing Clinic audiologists, speech-language pathologists, or students under the direct supervision of audiologists or speech-language pathologists, to conduct requested clinical services at the University of Georgia Speech and Hearing Clinic. I understand that services will be completed by a state-licensed and nationally certified audiologist or speech-language pathologist or by a student under direct supervision.

I agree that for educational purposes, clinic sessions may be observed by UGA Communication Sciences and Disorders faculty and student clinicians. I agree that the UGA Speech and Hearing Clinic personnel may audio record, videotape, or store sessions in an electronic format. Recordings of sessions may be used for educational purposes only. I also authorize the use of clinical case discussions for teaching purposes. I agree that all information will be held in the strictest confidence legally possible. I understand my clinician must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information.

I agree that permission must be granted in writing before I may take photographs of clinic sessions. I understand that audio or video recordings of sessions are not permitted to be made by clients, caregivers, or other individuals who are non-clinic personnel.

AUTHORIZATION FOR CONSENT:

❒ I fully understand and accept the terms of this *Consent for Speech and Hearing Clinic Services*.

____
Client/Authorized Representative Signature* Relationship (if applicable) Date

AUTHORIZATION FOR DATA COLLECTION:

❒ I agree to allow testing or treatment data to be included in the ongoing pool of clinic research data, understanding that this material will not contain any identifying data, but rather that all data will be coded by consecutive subject number.

____
Client/Authorized Representative Signature* Relationship (if applicable) Date

ACKNOWLEDGEMENT OF PRIVACY NOTICE:

❒ I acknowledge that I received the UGA Speech and Hearing Clinic *Notice of Privacy Practices*. A copy of the *Notice of Privacy Practices* will be provided when requested in paper or electronic format.

____
Client/Authorized Representative Signature* Relationship (if applicable) Date

❒ A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because: ☐ Client refused to sign ☐ Client was unable to sign or initial because ____________________________________ ☐ Other (describe): ________________________________

____
Witness / Office Staff Signature Date

CONSENT TO CORRESPOND ELECTRONICALLY:

Email does not always provide a secure means of communication. There is a risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. More secure means of correspondence are always available, if you do not wish to transmit information via email. By completing this form, I understand and am willing to accept the risks involved with insecure email communication of my protected health information. Clinic personnel may email me at __________________________________@____________________________regarding my services and care.

____
Client/Authorized Representative Signature* Relationship (if applicable) Date

***If patient is a minor (under the age of 18), each section must be signed by a parent or legal guardian.**