Therapist: _____

Phone: _____

Location: _____

Speech, Occupational & Physical Therapy

Phone: 870.932.0090 **Fax: 870.930.9336**

Speech/Language screenings were given to your child at his/her daytime location as part of your child's daytime program. Your child's performance on the screenings indicated more screening and/or testing is needed. Please fill this paper out while you are at your child's school. If you have any questions, feel free to call the number above to speak with one of our therapists.

Confidential Patient Information

Child's Name_____ Daytime Location_____

Gender_____ DOB_____ Kindergarten Child Will Attend_____

Medicaid or AR Kids Number_____

Parent/Guardian_____ Relationship to Child_____

Physical Address_____ Mailing Address_____

Town _____ Zip Code _____ Home Phone #_____

Cell Phone #_____ Work Phone # _____ Message Phone # _____

Additional Information/Comments_____ Primary Care Physician_____

Parent/Guardian Signature _____

For Non-Medicaid Insurances

Front and Back of Insurance Card needed before evaluation can be administered.

Insured's First, Middle, and Last Name_____

Social Security _____ Place of Employment _____

Administrative Purposes Only

_____R'cd speech/language evaluation _____ Articulation Disorder_____ Language Disorder _____Duration of Therapy/week

Therapist(s)_____ Evaluation Date_____ TxRx_____

Speech, Occupational & Physical Therapy

Confidential Patient History

Child's Name:_____ AGE:_____DOB:_____Primary Care Physician_____

Child Lives With: (CIRCLE ONE) FATHER MOTHER BOTH GUARDIAN OTHER

OTHER CHILDREN UNDER THE AGE OF TEN IN THE CHILD'S HOME:

NAME	RELATIONSHIP	GENDER	DOB	AGE
_____	_____	M / F	_____	_____
_____	_____	M / F	_____	_____
_____	_____	M / F	_____	_____
_____	_____	M / F	_____	_____

LIST ALL DEVELOPMENTAL CONCERNS OR PERTINENT MEDICAL HISTORY? (Medicines, surgeries, lack of progress ect.)

_____

Has the child been treated for VISION LOSS? YES/NO HEARING LOSS? YES/NO If yes to either, WHEN?_____

WHERE?_____WHAT WAS THE DIAGNOSIS?_____

HAS YOUR CHILD EVER BEEN SEEN BY AN EAR, NOSE & THROAT SPECIALIST? YES/NO WHO?_____

WAS YOUR CHILD FULL TERM? Yes/No IF NOT, HOW PREMATURE WAS HE/SHE?:_____

HEALTH AT BIRTH: EXCELLENT/GOOD/POOR? PLEASE EXPLAIN:_____BIRTH WEIGHT:_____LBS_____OZ

HOW OLD WAS CHILD WHEN: WEANED?_____ CRAWLED?_____ WALKED?_____

DOES THE CHILD USE: SINGLE WORDS? YES/NO SENTENCES? YES/NO PHRASES? YES/NO SPEAK CLEARLY? YES/NO

Has the child ever been tested for and/or placed in speech/language/occupational/physical therapy? YES/NO

When?_____ Where?_____

I give Communication Made Easy Inc. permission to perform any speech/language, occupational, physical therapy evaluation and/or therapy deemed necessary; bill any insurance including Medicaid/Arkids; release evaluations and therapy documentation to daytime care facility, public schools and the primary care physician as needed.

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____

PRINTED NAME:_____