Thank you for your interest in an evaluation at Mitchell's Place for speech and/or occupational therapy. We look forward to meeting you and your child.

To best help your child, we are asking that you complete the enclosed paperwork and return to Mitchell's Place.

You may send the paperwork to Shell Sheffield via:

- Email at vsheffield@mitchells-place.com
- Fax (205)957-0298
- Regular mail at 4778 Overton Road Birmingham Alabama 35210

We will file with your insurance and you will be responsible for any charges not covered by your insurance company. If you have questions about billing, you can contact the billing office at Mitchell's Place for an estimate of the deductible and/or payment that will be due on the date of the evaluation.

A Prescription to "evaluate and treat as necessary" is required for all Occupational Therapy and Speech Therapy evaluations. Parents are responsible for obtaining these RX's from child's pediatrician.

Please feel free to contact me at 205-957-0294 with any questions.

Sincerely,

Shell Sheffield

Administrative Assistant

New Patient Information

Patient's Name: _____ DOB: _____

Parent's First/Last Name: Mom: _____Dad:_____

Does child live with both parents? YES NO if no, who has custody? _____

Address where child lives: _____

Is this different from billing address? YES NO If yes, what is billing address: _____

_____

Home Phone: _____ Mom cell: _____Dad cell: _____

Work Mom: _____Work Dad _____

Mom's Email: _____ Dad's email: _____

INSURANCE: _____

Policyholder name: _____ DOB: _____

Employer: _____

Member ID Number: _____Group Number: _____

****Please bring your insurance card(s) with you for your first visit****

Referring Physician: _____Phone Number _____

Pediatrician: _____Phone Number: _____

Address: _____

Referred by: _____

Please read the attached Notice of Privacy Practices (HIPAA Notice) and sign acknowledgement form. Return to Mitchell's Place front office staff.

Please read and sign the attached Financial Policy. Return to Mitchell's Place front office staff.

Please read and sign the attached Consent to Treatment and Patient's Rights. Return to Mitchell's Place front office staff.

CONSENT TO TREATMENT

Patient/client _____

I, _____ the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Mitchell's Place. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Mitchell's Place encourages that this decision be discussed with the treating psychologist. This will help facilitate a more appropriate plan for discharge.

Non-voluntary Discharge from treatment: A client may be terminated from Mitchell's Place non-voluntarily, if (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic and /or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payments in a timely manner. The client will be notified of the non-voluntary discharge by certified letter. The client may appeal this decision or request to reapply for services at a later date. Client Notice of Confidentiality: The confidentiality of patient records maintained by Mitchell's Place is protected by federal and/or state law and regulations. Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at Mitchell's Place, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substance that are potentially harmful. It is the duty of Mitchell's Place to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parent of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client

data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Mitchell's Place.

_____ _____

Signature of client/legal guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness Date

OUTPATIENT SERVICES POLICY AND PROCEDURE STATEMENT

1. When you arrive for your therapy appointment, please sign in at the front desk and wait in the lobby. Your therapist will be notified upon your arrival.
2. We ask that you remain at Mitchell's Place during your child's appointment. If you must leave due to an emergency, please leave your cell phone number with the front desk.
3. If you are late for an appointment, your therapist may not be able to see your child that day. If the therapist is able to see your child, the session will end at the scheduled time. Patients who are habitually late may be discharged from treatment.
4. If your child is scheduled for a standing weekly appointment and attendance drops below 50% for any month, you may be discharged from your therapist's regular schedule.
5. If your child is sick or has a fever, please do not bring him/her for therapy. Your child must be symptom free without medication for 24 hours before attending therapy.
6. If a patient cannot attend a scheduled therapy appointment, it is your responsibility to contact Mitchell's Place at least 24 hours prior to the scheduled appointment in order to avoid being charges. Late cancellations will be charged a $20.00 cancellation fee, and no shows will be billed at the full fee. Your insurance company cannot be billed, and you will be responsible for the entire charge.
7. If siblings or friends accompany you to Mitchell's Place, please stay with them in the waiting area, unless instructed differently by your child's therapist. Children must be accompanied by an adult at all times.

I have read the departmental policies and understand its content.

_____ _____

Parent signature Date

_____ _____

Witness signature Date

FINANCIAL POLICY

Welcome to Mitchell's Place! Thank you for giving us an opportunity to serve you. The following is a statement of our financial policy, which we require that you read and sign prior to provision of service. The signed copy is retained in your client file. A copy of this is available to you for your records- please ask someone at the front desk or our billing coordinator.

PAYMENTS:

Payments are due and payable at the time of service. This includes all applicable co-pays, deductibles, co-insurance and services not covered by your insurance. We cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility under your insurance plan. In fact, such waiver may violate state and federal laws. Mitchell's Place accepts cash, checks, money orders, debit cards and credit cards (Visa and MasterCard).

Co-pays and fees can be paid in advance or done on an auto draft basis. Please contact the billing coordinator if you are interested in either of these payment options.

There is a $25.00 service charge for returned checks.

INSURANCE:

Insurance coverage varies by individual policy. Please become familiar with the benefits and requirements of your insurance company. In order to file a claim with your insurance company, it is extremely important that we obtain complete information from you. Please bring your insurance card with you to your initial appointment, and provide us with an updated copy if your insurance changes during your treatment with us. Preauthorization is required from some insurance plans. Our office will assist you in obtaining pre-authorization and referrals; however it is your responsibility to make sure referrals and pre-authorizations are obtained PRIOR to services being rendered. Additionally, it is your responsibility to keep track of the number of services provided should there be a limited amount provided by your insurance company, as we are not able to keep track of outside services you receive. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary or ineligible (not covered by your insurance policy, policy has expired or is not in effect at the time of service). If the insurance company does not pay the charges amount, you are responsible for the balance and these charges will be billed in full.

Please note that if you have medical insurance coverage, it should be understood that this is an agreement between you and your insurance company. You are responsible for the payment of services provided at Mitchell's Place regardless of the status of your insurance claim.

After your insurance has made a payment to us, we will send you a statement for any remaining balance on your account. This bill is due upon receipt.

OUTPATIENT SERVICES (Speech, Occupational Therapy, Psychiatry, Psychology):

We will file your insurance after your visit and will apply any payment received to your account (if you receive ongoing services). You are responsible for payment of any co-payment or co- insurance at the time of service. If we receive an overpayment on your account, we will refund the insurance payment to you (if you receive one-time services such as psychological testing).

EARLY LEARNING PROGRAM/AFTER SCHOOL SOCIAL AND ACADEMIC ENRICHMENT PROGRAM (ASAP)/ TEACH ME/ EXTENDED DAY PROGRAM / ABA SERVICES:

Fees for these programs are due at the beginning of each session and at the first of the month thereafter.

SUMMER CAMP SESSIONS:

A deposit is due at the time a reservation is made for any of our summer camp sessions (one deposit per session). The remaining fees are due on the start date of the attending camp session.

PSYCHOLOGY/PSYCHIATRY BILLING:

Indirect services, including but not limited to, consultations with other service providers, phone conversations or emails longer than 15 minutes, and letters to providers/schools, will be billed at a rate of $190.00. Per hour. Please understand that your insurance will not cover any charges for missed appointments or late cancellations (less than 24 hours advance notice), or the indirect services listed above. Missed appointments or late cancellations will be charged at an hourly rate of $40.00. No shows will be charged at an hourly rate of $190.00 or at a rate determined by the psychiatrist/psychologist.

NO SHOWS/CANCELLATIONS:

If you need to cancel an appointment, please call to give a 24-hour notice. You may leave a message with our answering service after normal business hours and on weekends or holidays.

If you do not show up for an appointment and no notice was given, you will be charged the full fee for your appointment. If you give less than 24 hour notice of the cancellation you will be charged a $20.00 cancellation fee.

PAST DUE ACCOUNTS:

Accounts over 30 days past due will receive notice for discontinuation of service.

All accounts over 90 days past due will be placed into collections processing. Any outstanding balance at the time of graduation will be sent to collections.

QUESTIONS:

If you have any billing or insurance related questions or need assistance, please contact the billing coordinator between the hours of 7:30 am and 4:00 pm Monday – Friday at 957-0294

I understand that I am responsible for my bill, not my insurance company. If my insurance company does not pay in a timely fashion, I will promptly pay my bill in full. I hereby agree to pay in full, all amounts due for services rendered by Mitchell's Place, Inc. no later than thirty days from the date services are rendered unless other specific written arrangements are made. In the event of default in the payment of said services, I waive, as to the debt, all rights of exemptions and laws of Alabama or any other state as to the personal property, and agree to pay all costs of collections or securing or attempting to collect or secure said indebtedness, including all reasonable attorney fees. By signing below, I authorize the release of any medical records or other information necessary to process any insurance claims and assign benefits to Mitchell's Place.

Thank you for taking the time to read our financial policy. We hope that this information helps you to anticipate your costs for services provided at Mitchell's Place. Please let us know if you have any questions or concerns.

I have read Mitchell's Place Financial Policy. I understand what I have read and agree to comply with the policy.

Patient/student name: _____Date _____

Signature or responsible party _____Date _____

NOTICE OF PRIVACY PRACTICES

This notice describes how confidential information about you may be used and how you can get access to this information. Please review it carefully.

Federal Law requires us to maintain the privacy of your Protected Health Information (PHI) and other information that could be used to identify you and to provide you this notice of Privacy Practices, which describes how we may use and disclose your PHI and other information to carry out treatment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health conditions and related health care services. At Mitchell's Place, protected information also includes information regarding any of our educational services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by the physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care/educational services to you and to pay your health care bills, to support the operation of business, and other use required by law. Treatment: we will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used to obtain payment for your health care services, for example, we may provide PHI to your insurance company to obtain authorization and payment for services rendered.

Health care operations: we may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign in sheet at the registration desk where you will be asked to provide your name. We may also call you by name in the waiting room when the physician/therapist is ready to see you. We may use or disclose your PHI to contact you for appointment reminders, test results, or health related services that may be of interest to you, as well as to check on your treatment, progress and satisfaction with our services.

We may use or disclose your PHI in the following situations without your authorization: As required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services. Other permitted and required uses and disclosures will be made only with your authorization. This includes requests for medical/educational records. Once given, you may withdraw authorization at any time in writing. You have the right to inspect and copy your PHI. Under federal law you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in, a legal proceeding and PHI that is otherwise prohibited. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care options. Your request must be in writing and state specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If we believe that it is in your best interest to permit use and disclosure of you PHI, it will not be restricted. You then have the right to use another health care professional. You may request that we restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full for the health care services.

You have the right to opt out of receiving fundraising communications.

You have the right to obtain a paper copy of this notice from us upon request.

You have the right to have us amend your PHI. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. Your request must be made in writing. You have the right to be notified following a breach of unsecured PHI.

You may complain to us or to the secretary of health and human services if you believe your privacy rights have been violated. You may make a complaint with us by contacting our Executive Director at 205-957-0294. We will not retaliate against you for filing a complaint.

_____ _____

Signature Date

Why are you seeking an evaluation? What is the primary area of concern?

_____

_____

- Concerns about Autism
- Concerns about Asperger's Syndrome
- Concerns about learning disabilities/academic concerns
- Concerns about mental retardation
- Behavioral problems
- Emotional difficulties such as anxiety and depression
- Delayed language skills
- Articulation concerns
- Delayed fine motor skills
- Sensory processing or sensory integration disorder
- Feeding concerns
- Social skills concerns, delays or difficulties
- Social language difficulties (pragmatic language difficulties)

What are the secondary areas of concern to be addressed in this evaluation?

- Concerns about Autism
- Concerns about Asperger's Syndrome
- Concerns about learning disabilities/academic concerns
- Concerns about mental retardation
- Behavioral problems
- Emotional difficulties such as anxiety and depression
- Delayed language skills
- Articulation concerns
- Delayed fine motor skills
- Sensory processing or sensory integration disorder
- Feeding concerns
- Social skills concerns, delays or difficulties
- Social language difficulties (pragmatic language difficulties)

Client's chief problem as you see them Ex. Describe your child's behavior problems, problem solving skills, personal/social skills, fine motor, gross motor, sensory concerns and or speech/language development	When did problem begin? Or when did your concerns begin? At what age?
1	
2	
3	
4	
5	
Clinician use only. Do not write in this space. _____ _____ _____ _____	

Has your child ever been given a diagnosis below?		If yes, when was diagnosis given? By Whom?
Autism		When? _____ By Whom? _____
Asperger's Disorder		When? _____ By Whom? _____
Pervasive Development Disorder – not otherwise specified		When? _____ By Whom? _____
Fine motor delays		When? _____ By Whom? _____
Sensory concerns or sensory integration disorder		When? _____ By Whom? _____
Articulation delays		When? _____ By Whom? _____
Receptive or expressive language disorder		When? _____ By Whom? _____
Social pragmatic communication delays or social delays		When? _____ By Whom? _____
Mental retardation or learning disability		When? _____ By Whom? _____
Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder		When? _____ By Whom? _____
Depression or Anxiety		When? _____ By Whom? _____
Other _____		When? _____ By When? _____

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_____
_____
_____
_____

Child custody issues:

Are there any current custody issues?

If yes, please explain

_____

_____

If applicable, what are the custody or visitation agreements?

_____

_____

IF applicable please attach copy of court order regarding custody of child

Are both parents involved in the regular care of the child? _____

Are there other adults involved in the regular care of the child? _____

Who will be attending the evaluation? _____

Do all parties involved in the care of the child agree on the need for an evaluation of this child?

_____

Brothers and sisters (including half-brothers/sisters)	Age	Learning and or medical problems
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

School and educational history

If your child is currently involved in ongoing therapy or has an individualized educational plan (IEP) with the school system, Please copy and enclose with this form

Name of current school _____ grade _____

Teacher Name _____

School system _____

Name of previous schools attended

_____

_____

_____

Current placement in school

- regular classroom
- special education classroom explain _____
- resource room
- alternative school
- home school
- other _____

Has your child repeated any grades? IF yes which one(s) _____

Has your child been suspended this school year? If yes why? _____

Has your child been tested for special education placement by the school? If yes, please bring

Copies of testing and IEP's

Describe how your child is doing in School.

_____

_____

If your child has received any of the following special services, please give age of child when services started and date services ended or current frequency of services

School Therapy	Grade/age of child when services started	If appropriate, date services ended	Current frequency of services	Specific goals being addressed
Physical Therapy				
Occupational Therapy				
Speech/language therapy				
Special instruction				
Vision impaired				
Hearing impaired				
Psychologist/counselor				
Social skills				

Other, specify

_____

_____

Prenatal and birth history

Mother's general health during pregnancy (illness, accidents, medications..etc)

_____

_____

_____

Length of pregnancy _____ length of labor _____ Birth weigh _____

General condition _____ Miscarriages _____

Type of delivery

Head First _____ Feet First _____Cesarean _____ other _____

Were there any unusual conditions that may have affected the pregnancy or birth?

_____

_____

_____

Was the child hospitalized after birth? If yes, Why?

_____

_____

_____

Biological mother's age at birth _____

If the child was adopted, child's age at adoption _____

Was prenatal care received? ____YES ____NO

Did the biological mother use any of the following during pregnancy?

- Alcohol
- Over the counter Medications
- Cigarettes
- Prescription Medications
- Illegal or street drugs, which ones? _____
- Other _____

Clinician use only. Do not write in this space.

_____
_____
_____
_____

Medical History

If applicable, please provide the approximate age at which your child had the following illnesses/conditions:

Allergies-	Asthma-	Chicken Pox –
Colds -	Sleeping Problems -	Croup -
Dizziness-	Draining Ear-	Ear Infections-
Encephalitis-	Feeding Problems-	Headaches –
High Fever -	Influenza-	Growth Problems-
Measles -	Meningitis-	Mumps-
Pneumonia-	Seizures-	Sinusitis-
Tonsillitis-	Head Injury-	Lead Poisoning-

Current weight _____

Current Feeding Method (check all that apply) Bottle fed _____ Baby food _____

Table food _____ Special diet _____

Does your child have a specific medical diagnosis? Or a significant health problem? If so please describe.

_____
_____
_____

Has your child had any surgeries? If yes, what type and when?

_____
_____
_____

Describe any major accidents or hospitalizations, including visits to the emergency room?

_____
_____
_____

Is your child taking any medications currently? If yes, please list the name of the medication, the dose and the frequency.

Name of medication	Who prescribes medicine	Dose/frequency	Why prescribed?

Has your child taken any medications in the past? If yes, please list the name of the medication, the dose and the frequency.

Name of medicine	Who prescribed medicine	Dose	When stopped	Why stopped	Why originally prescribed

Please describe all allergies your child has (medication, food, environment)

_____
_____
_____

_____

Developmental History

Provide the approximate ages at which your child began to do the following activities. (You can use early, late or on time if age is unknown)

Smile -	Crawl-
Coo/babble-	Stand Alone –
Roll over -	Walk Alone-
Sit alone-	Feeds self-
Single words-	Dresses self-
Phrases-	Toilet trained-
Short sentences-	Bowel-
	Bladder-

Your child communicates by which of the following (check all that apply)

Crying-	Sentences-
Playful sounds-	Sign language-
Pointing with index finger-	Words-
Phrases-	

How much of your child's speech is understandable to you? ___some ___most ___all

How much of your child's speech is understandable to others? ___some ___most ___all

Does your child have any problems?

- Understanding what someone says ___yes ____no
- Talking ___yes ____no

Has your child hearing been tested? ___yes ____no

Was hearing loss reported? ___yes ____no

If yes, who tested? _____

If yes, when tested? _____

If yes, what were the results? _____

When did you first become concerned with your child's development?

_____

_____

_____

What prompted your concerns about his or her development?

_____
_____
_____

Did a regression of skills or a loss of skills ever occur in your child's development? ____yes ____no

If yes, when did this regression of skill or loss of skills occur?

_____
_____

If yes, describe the regression of skill or loss of skills?

_____
_____

Since you first noticed the delay in your child's development, how has your child's development changed?

_____
_____
_____

Family History

Is there any family history of the following?

Condition	Mother's Family	Father's Family	Sibling full or half	who
speech or language impairment				
Autism or Autism Spectrum Disorder				
Visual Impairment				
hearing impairment				
Learning disability				
drug or alcohol abuse				
seizure disorder				
Behavior problems				
emotional difficulties anxiety or depression				
bipolar disorder				
chronic illness				
ADHD/ADD				

Tics or involuntary movements				
Diabetes				
Schizophrenia				
Thyroid problems				
Other (please specify)				

clinician use only. do not write in this space.

_____
_____
_____
_____

Has the department of human resources (DHR) ever been involved with this child ___yes ___no

Date of DHR involvement _____

Reason for Involvement _____

If yes, explain

_____
_____
_____

Clinician use only. Do not write in this space

_____
_____
_____
_____
_____
_____

Family Data

Please list all individuals living in the child's household

Name	Age	Relationship	Learning or Development Problems	Occupation, if appropriate

Please list all other family members or caregivers not currently living or residing with the patient (including step siblings, siblings, and biological parents)

Name	Age	Relationship	Learning or Development Problems	Occupation, if appropriate

Please provide the following information regarding specialists (speech/language pathologists, occupational therapists, physicians, psychologists, and special education teachers etc. who have evaluated your child?

type of service provider	agency/provider name	agency/provider complete address	dates seen
hospitalizations			
pediatrician			
family physician			
neurologist			
psychologist			
eye specialist			
hearing specialist			
speech language therapists			
occupational therapist			
physical therapist			
geneticist			
Children's rehab. service			
public health dept.			
department of human resources			
other specify			

Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination? If yes please describe

_____
_____
_____
_____

Hand preference _____right _____left _____both _____Not sure

Are there or has there ever been any feeding problem (problems with sucking, swallowing, drooling, chewing etc.) If yes please describe

_____
_____
_____
_____

Is your child a picky eater? If so what foods will he/she eat?

_____
_____
_____
_____
_____

Is your child on any special diet? Does he/she take any nutritional supplements? If yes please describe

_____
_____
_____
_____

Describe your child's response to sound (response to all sounds, loud sounds only, extremely sensitive to loud noises etc.)

_____
_____
_____
_____

Does your child have outburst or meltdowns due to anger, frustration, and or sensory overload? If so please describe frequency and intensity.

_____
_____
_____
_____

If so are there strategies that you have used that are helpful in correcting this behavior?

_____
_____
_____
_____

If during these behavioral outburst, which behaviors occur?

- hitting himself or herself
- kicking others
- head banging
- throwing things
- biting
- hitting others
- screaming
- excessive crying
- destruction of property
- other

How would you describe your child?

- usually very active
- active sometimes, but can play quietly
- usually not active
- usually happy
- can be moody
- demands attention
- aggressive towards self or others
- difficulty attending to activities
- prefers motor activities
- prefers sit down activities

Please describe your child's play/social skills?

_____
_____
_____
_____

Does your child experience trouble with making friends ____yes ____no

If yes please describe

_____
_____

Does your child experience trouble keeping friends ____yes ____no

If yes please describe

_____
_____

Does your child have trouble with making or maintaining eye contact ____yes ____no

_____
_____

Does your child experience trouble with reciprocal or back and forth social conversation ___yes ___no

If yes please describe

_____
_____

Does your child experience trouble becoming obsessed with a given topic ____yes ____no

If yes please describe

_____
_____

Does your child experience trouble with understanding social rules ____yes ____no

If yes please describe

_____
_____

Does your child experience trouble with personal space ____yes ____no

If yes please describe

_____
_____

Does your child experience trouble with playing with toys in an appropriate manner ____yes ____no

If yes please describe

_____
_____

In regard to the child's speech and language development what us the primary area of need (s) check all that apply.

- Articulation or producing the speech sounds
- Expressive Language or what the child is able to say
- Receptive Language or what the child understands
- Pragmatic Language or the social use of language including social interaction

In regard to the child's motor development what's the primary area of need(s) check all that apply

- clumsiness/uncoordinated
- trouble using two hands together or crossing midline
- handwriting
- fine motor delays
- motor coordination or motor planning

In regard to sensory concerns or how a child reacts to given events in the environment is the child (check all that applies)

- over sensitive or reactive to sound
- under sensitive or reactive to sound
- over sensitive or reactive to light

- under sensitive or reactive to light
- picky eater
- over sensitive to pain
- under sensitive to pain
- doesn't like having things on his/her hands or touching certain things
- sensitive to certain types of clothing or fabrics
- always having to touch different textures
- smells things you would not expect a child to smell
- seeks movement more than you would expect for a child his/her age
- avoids movement activities such that it impacts daily child activities

What does your child enjoy doing in his/her free time

_____
_____

What are your child's special interests, like and dislikes? What rewards or motivates your child

_____
_____

Please name three social goals that you would like for your child to accomplish this year

_____
_____
_____
_____

Please name three academic goals that you would like for your child to accomplish this year

_____
_____
_____
_____

Has your child had any prior counseling, psychiatric care, or psychiatric hospitalizations?

Hospital or doctor's name	Phone number	Date seen	Reason/ Recommendations

Self Help Checklist

Can your child? Does your child?	Yes/No	Notes: please provide an additional comments regarding your child's self-help skills
Cooperate with dressing (holds out arms and feet)		
Push arms through sleeves and legs through pants		
Push down/pulls up pants		
Pull off socks and shoes		
Put on socks and shoes (without tying)		
Identify front/back of clothing		
Remove/put on pullover garment independently		
Snap or button fasteners on clothing		
Tie shoes		
Dress unsupervised		
Toilet trained		
Complete toilet hygiene independently		
Wash and dry hands		
Brush teeth		
Brush hair		
Bathe		
Wash hair/face		
Drink from a regular cup		
Finger feed		

Regarding self-help skills. Please list additional comments:

_____
_____
_____
_____

**********For clinical Use only**********

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Child scheduled for • Full evaluation • Psychology only • Slp only • Ot only • Psych and slp • Psych and ot • Slp and ot	Paperwork given to • Sl • Bw • Ss •
Date of evaluation _____	Date of Feedback _____
Therapist noticed on computerized schedule	