Barnett Therapy Services, LLC

Partnering with Families to Improve Lives

Welcome! I am excited that you have decided to allow us to partner with you and your child to improve communication!

Here is the Case History Form, Release of Medical Information and the Media Consent form that you will need to complete before the evaluation begins. Print out the forms (pages 2-9), fill it out as completely as possible and get it back to us! You can scan them and email them, send it via mail or hand it to us! If your child is at a local preschool or childcare center, you can leave it there in an envelope!

We look forward to working with your child! Let me know if you have any questions!

- Lauren Barnett, MA, CCC-SLP

Barnett Therapy Services

795 Executive Drive, Oviedo Florida 32765
Main: 407-325-0427

Case History Form

Child's Name:_____ **Birthday**:_____ **Gender**: _____

Preferred Email address: _____
Preferred phone number: _____
Mother's Name: _____
Mother Address: _____
Mother's cell phone: _____
Father's Name: _____
Father's Address (if different):_____
Father's cell phone: _____

Child lives with (check one):

- Both Parents
- One Parent
- One Parent and Step Parent
- Foster Parents
- Other_____

Sibling's Names Ages Speech/Hearing Problems

_____
_____
_____
_____

Describe the primary reason you are seeking an evaluation and/or treatment:

_____
_____

Is there a language, other than English, spoken at home? Yes No

What other language(s)? _____

What is your child's dominant language? _____

What language did your child learn first? _____

What language is dominant at home? _____

Is your child exposed to other languages at other locations? (daycare, babysitters, etc…) Yes No What other language(s)? _____

Pregnancy/Birth History

Was he/she born on time? Yes No If not, how many days/weeks early? _____
Did your doctor say your pregnancy had complications? Yes No
If so, please describe them._____
Describe the birth_____
_____
Did your child nurse or take the bottle? _____
Were there any difficulties? _____
Did the child gain weight as expected? _____
Birth weight_____ APGAR score _____
Was a Hearing Screening conducted at birth? Pass or fail _____
General condition after birth? _____
_____

Medical History

Has your child been diagnosed with any medical diagnosis? _____
Has your child been hospitalized? If yes, please explain and give dates. _____
Has your child had any surgeries since birth?_____ If yes, please explain and give dates.
_____
Has your child had a MRI or CT scan? _____ If yes, please give the dates and results.
_____
Is your child current under a physicians care? _____ If yes, please explain.
_____
Please list any medications your child takes regularly:
_____

Hearing and Vision

Has your child's hearing ever been tested? Yes No
When was your child's hearing testing? _____
What were the results? _____

Do you have any concerns with your child's hearing? Yes No If yes, please describe:
_____

Has your child had recurrent ear infections? Yes No
Approximately how many a year? _____ How many to date? _____
Does the child have tubes in the ears now or scheduled? _____

Has your child's vision ever been tested? Yes No
Does he or she wear glasses?_____
When was your child's vision testing? _____
What were the results? _____

Describe your child's vision: _____ Do you have any concerns? Yes No
If yes, please describe: _____

Allergies
Does your child have **any** allergies, food allergies or asthma?_____
If yes, please describe _____
_____

Behavior
Has your child been diagnosed with a behavior disorder, attention deficit disorder? Yes No
If so, when was it diagnosed and is the child currently on medication or a behavior program?
_____

What are your child's interests? _____

What reinforcers does your child like? (stickers, candies, toys etc.) _____
May I give a lollipop occasionally as a treat? _____

Medical Professionals involved in the care of your child
Pediatrician's name _____ Name of Practice _____
Phone number _____
Did you receive a referral from your Pediatrician for speech therapy?_____
Does your child visit this pediatrician for well-child check ups? Yes No
Does your child visit this pediatrician on an as needed basis (illnesses/injuries) Yes No

Other Medical Professionals
Name _____ Name of Practice _____
Name _____ Name of Practice _____

Developmental History

If your child is over the age of 3, please indicate if the milestones listed below were:
___ generally mastered at an appropriate age OR ____ generally behind in development

If "generally behind," please describe: _____

If your child is under the age of 3, what is the approximate age at which your child could:

_____ Hold head up
_____ Roll over
_____ Sit up
_____ Stand up
_____ Walk
_____ Babble
_____ Say first word
_____ Put two words together
_____ Speak in short sentences

Does your child… (please answer each one)
- eat well? Yes No
- avoid any food textures or food groups?_____
- have a PEG tube or G-tube for nourishment? Yes No
    If yes, when was it inserted and for how long? _____
- avoid any activities of daily living (teeth brushing, hair brushing, taking a bath) _____
- temperatures or textures?_____

Did/Does your child suck his/her thumb or use a pacifier? Yes No
    Which did your child use: thumb pacifier
    If your child still does use a thumb/pacifier, when is it used: _____
    If your child did previously, when they stop?_____
How much does your child weigh now?_____

Do you have any concerns about Autism? Yes No
Does the pediatrician or another caregiver have any concerns about Autism? Yes No
If yes, please describe _____
_____

Speech-Language-Hearing History

Who first noticed a speech or language delay (family member, friend, Doctor, etc.)
_____
Please describe your concern with your child's speech and/or language:
_____
_____
_____

Was your child screened by Barnett Therapy Services? Yes No
    (if yes, we have copies of the results!)
Has your child had a speech or language screening or evaluation else where? Yes No
    If yes, where and when?_____
What were the results (attach copies of reports if available): _____
Has your child ever had speech therapy? Yes No
If yes, where and when? _____
What was he/she working on? _____
Did he/she make progress? _____
Has your child ever had any other therapy or evaluation (occupational, physical, counseling, etc) Please describe: _____

Current School Information

Current School: _____
Current Teacher and Grade: _____

Does the teacher/staff have concerns? Yes No
Please describe: _____

Favorite part about school: _____

Current Speech-Language-Hearing

Is your child aware of any communication difficulties? Yes No
If yes, how does he/she respond? _____

How does your child currently communicate? (examples: points only, points and grunts, babbles only, speaks at a conversational level, etc…) _____

In regards to the direction of therapy, please answer the following questions:

In the following area(s), I would like my child to improve his/her communication (describe):
At school: _____
At home: _____
Socially: _____
Other: _____

My child would like to improve in the following area(s) _____
_____

High Frequency Words

To guide the direction of therapy, so that what we work on makes a difference immediately in your child's life, please list words that you feel your child is highly motivate to say based on preferred toys, foods, places, people/pets, actions or other words which we target as a part of therapy (**note**: **these should be words your child wants to say but currently does not say or does not say correctly**):

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.
6. _____.
7. _____.
8. _____.
9. _____.
10. _____.
11. _____.
12. _____.
13. _____.
14. _____.
15. _____.
16. _____.
17. _____.
18. _____.
19. _____.
20. _____.

Additional Comments

Name (Print): _____

Relationship to child: _____

Signature: _____

Thank you for taking the time to complete this Case History Form. If you have any questions, please let us know!

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Release of Medical Information

Child's Name: _____ Date of Birth:_____

I request and authorize Lauren Barnet, MA, CCC-SLP or a member of Barnett Therapy Services to **release** necessary and pertinent medical information to classroom teachers, school based Speech Language Pathologists, physicians, other therapists, teachers/staff, case managers and insurance companies as needed for my child.

I request and authorize Lauren Barnet, MA, CCC-SLP or a member of Barnett Therapy Services to **obtain** medical and pertinent medical information from the client's classroom teachers, school based Speech Language Pathologists, physicians, other therapists, teachers/staff, case managers and insurance companies for my child as needed including:

Name of Company	Address	Contact Number

_____ _____

Parent/Legal Guardian Date

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Media Consent

Child's Name: _____ Date of Birth:_____

Part of the joys of seeing children in their natural environment means that they are often seen at preschools, childcare centers and private schools. Thus the parents cannot see what we are working on. The Speech Notebook is a great means of communication, however, sometimes a quick 30 second video or picture will more clearly demonstrate what needs to be practiced at home.

This requires a video and/or picture to be taken of your child and sent to you often via text or email. Due to the nature of email and text security, there is always a possibility that the data could be accessed by unintended users.

Photos or videos will be taken at least once per month and sent to you.

If your child is a part of a group activity, the photos may be shared with those attending.

If you would like to place conditions on your child's photos or have your child removed from groups where photos are taken, please comment here:

Check One:

___Yes ___No My child may be photographed/video recorded and receive photos of activities via text and/or email.

_____ _____

Parent/Legal Guardian Date