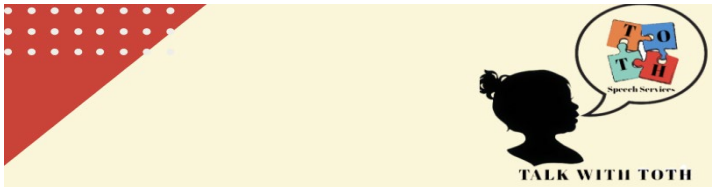


Pre Teen/Teen Intake Form

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

HOME ADDRESS:_____

CITY, STATE, ZIP _____

Parent #1/Legal Guardian:_____ Occupation:_____

Employer:_____ Phone:_____

Parent #2/Legal Guardian:_____ Occupation:_____

Employer:_____ Phone:_____

PHYSICIAN NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

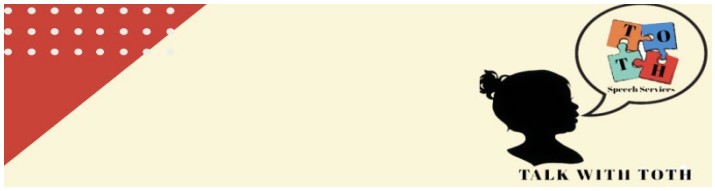
Emergency Contact

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____ RELATIONSHIP:_____



Background Information:

Do you have any concerns regarding speech? ☐ YES ☐ NO ☐ N/A

If you answered yes, please describe your concerns:

_____

Do you have any concerns regarding language? ☐ YES ☐ NO ☐ N/A

If you answered yes, please describe your concerns:

_____

Do you have any concerns regarding swallowing? ☐ YES ☐ NO ☐ N/A

If you answered yes, please describe your concerns:

_____

When were the above concerns first noticed? _____

Has the issue changed (worsened/resolved) since it was first noticed. If so, please explain.

_____

_____

Has a specialist seen the patient regarding any of the above concerns? ☐ YES ☐ NO

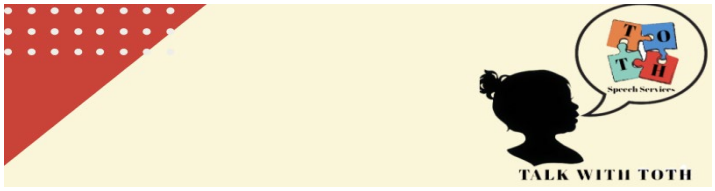
Date of last visit: ___/___ /_____

If you answered yes, please provide any conclusion or recommendations:

_____

_____

May we obtain copies of previious evaluations and/or discharge reports? ☐ YES ☐ NO



Social History

Patient's Current Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated/Not Divorced ☐ Widowed ☐ Domestic Partnership

SPOUSE'S NAME (if applicable):_____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

Do you have children? ☐ YES ☐ NO

Child's Name: Age: Gender:

_____

_____

_____

Highest grade, diploma or degree earned: _____

Please describe current or past occupation/employer (leave blank if student)

_____

_____

_____

Please describe any hobbies/interests:

_____

_____

What is the best way you learn new things: Written Instruction ☐ Verbal Instruction ☐

Hands on learning ☐ Other ☐ If other, please describe:

_____

_____

Medical History:

Do you currently have any medical diagnoses? ☐ YES ☐ NO

If you answered yes, please describe what they are:

_____

_____

Are you currently taking any medication? ☐ YES ☐ NO

If you answered yes, please list name of medication and dosage amounts:

_____

_____

Do you have any known allergies? ☐ YES ☐ NO

If you answered yes, please list:

_____

_____

Has the patient's vision been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Opthamologist's name and results:

_____

_____

Has the patient's hearing been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Audiologist's name and results:

_____

_____

Do you use English as a second language? ☐ YES ☐ NO

If you answered yes, what is your native language:

_____

Speech and Language Skills:

Do you have difficulty expressing your need and wants? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do others find it difficult to understand you? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you find it difficult to understand others? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you have short term and/or long term memory difficulties? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you have difficulty with word finding? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you find it difficulty with reading and/or writing? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Has there been any changes with your voice? (i.e. hoarse, breathy, loss)? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Speech and Language Skills:

Please check if you have difficulty with any of the following:

☐ Chewing food	☐ Drooling	☐ Moving food to back of mouth
☐ Increased meal times	☐ Watery eyes when eating	☐ Coughing
☐ Managing liquids	☐ Clearing food from mouth	☐ Choking

Other: _____

Are you currently on a modified dood and/or liquid diet? ☐ YES ☐ NO ☐ N/A

If you answered yes, please explain:

_____

_____

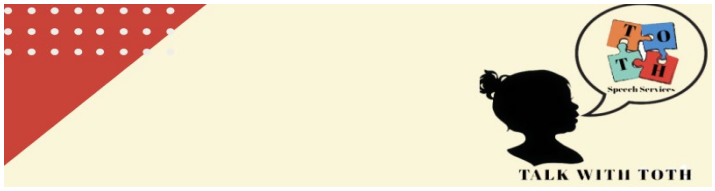
Are there any food/liquid textures that you avoid? ☐ YES ☐ NO ☐ N/A

If you answered yes, please explain:

_____

_____

Do you currently wear dentures? ☐ YES ☐ NO ☐ N/A



Activities of Daily Living:
Please check if you require assistance with any of the following:

◻ Dressing	◻ Toileting	◻ Cooking	◻ Eating
◻ Telling time	◻ Hygiene	◻ Housekeeping	◻ Driving
◻ Money management	◻ Tracking appoint-ments	◻ Shopping	

Other: _____

Therapy Goals:
What are your current speech/language related goals?

_____

_____

What are your prefered times available for therapy?

_____

_____

Please provide any additional information that may be helpful to the evaluation/treatment process:

_____

_____

The above information is true and completed to the best of my knowledge:

Patient Signature:_____ DATE: ____/____/_____

Print Name: _____

If other than patient, please indicate relationship _____

Notice of Privacy Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TOTH SPEECH SERVICES', LLC LEGAL DUTY

Toth Speech Services, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Toth Speech Services, LLC uses your personal health information primarily for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or for information about treatment alternatives or other health related benefits that could be of interest to you.

Toth Speech Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or for research studies and for emergencies. We also provide information when required by law.
In any other situation Toth Speech Services' LLC policy is to obtain written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at that time.

Toth Speech Services, LLC may change its policy at any time. When changes occur, a Notice of Information Practices will be provided to you. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in an emergency circumstance. Toth Speech Services, LLC will consider all such requests on a case-by-case basis but is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Toth Speech Services, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the US Department of Health and Human Services.

YOU MAY KEEP THIS NOTICE FOR YOUR RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

Medical Practice Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. This Notice of Privacy Practices describes the types, uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Toth Speech Services' health care operations. This Notice of Privacy Practices also describes my rights and duties with respect to my protected health information.

Toth Speech Services, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Patient Signature:_____ DATE: ___/___/_____

Print Name: _____

If other than patient, please indicate relationship _____

tothspeechservices.com
(561)-400-1931
tothspeech@gmail.com