LittleListeners
Helping young minds learn to listen

Pediatric Case History

Direct quotes from your responses may be used to write your child's report. Please be precise and consistent.

Child's Full Name: _____ Date: _____

How should we address your child (nickname): _____ Birthdate: _____

Gender: ☐ Male ☐ Female Preferred Hand for Writing: _____ Age: _____

Parents Names: _____ Marital Status: _____

☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ Guardians

Parents Occupation(s): _____

Home Address: _____

Street City State Zip Code

Home Phone Number: _____ Cell Phone Number: _____

Email Address(es): _____

Preferred method of communication: ☐ Home ☐ Cell ☐ Email

Siblings Names and Ages: _____ ☐ Only Child

Who lives in the home with the child? _____

What is the reason for today's visit? _____

Diagnosis (if known): _____

Primary Care Physician: _____ Phone Number: _____

Referral Source: _____ Phone Number: _____

How did you hear about Little Listeners? ☐ Referral Source ☐ Self Referred ☐ Other: _____

Birth History

Birth Hospital: _____ Gestational Age at Birth (length of pregnancy): _____ Weeks

Birth Weight: _____ ☐ Grams ☐ Pounds

Small for Gestational Age (SGA)? ☐ Yes ☐ No

Low birth weight? ☐ Yes ☐ No

Abnormal weight loss after birth? ☐ Yes ☐ No

Apgar scores normal? ☐ Yes ☐ No If not, what were the scores? _____

Were there any significant prenatal difficulties?

Viral infection in the first trimester (first 12 weeks) of pregnancy: ☐ Yes ☐ No

Maternal medical problems during pregnancy (morning sickness, threatened miscarriage, high blood pressure, etc.…): ☐ Yes ☐ No

Maternal emotional distress between pregnancy weeks of 23-28 weeks: ☐ Yes ☐ No

Excessive ultrasounds performed: ☐ Yes ☐ No

If yes to any of the above, please describe: _____

Medications taken during pregnancy: ☐ Yes ☐ No

If yes, please list: _____

Were there any significant delivery difficulties?

Prolonged labor: ☐ Yes ☐ No If yes, how long? _____
Fetal distress: ☐ Yes ☐ No If yes, please describe: _____
Breech position: ☐ Yes ☐ No
Forceps or Suction Delivery: ☐ Yes ☐ No If yes, circle which one
Caesarian Section (C-Section) performed: ☐ Yes ☐ No

NICU (Special Care) stay after birth? Yes ☐ No ☐ If yes, how long? _____
Ventilation required? Yes ☐ No ☐ If yes, how long? _____
Any significant infections? Yes ☐ No ☐ If yes, please describe: _____
Medications given? Yes ☐ No ☐ If yes, please list: _____
Treatment for Jaundice? Yes ☐ No ☐ If yes, please describe: _____
Any scars or physical abnormalities? Yes ☐ No ☐ If yes, please describe: _____
Any congenital defects? Yes ☐ No ☐ If yes, please describe: _____
Any other significant birth history? _____

Medical History

Has your child had any of the following medical problems? Please check appropriate column:

	No	Past	Present		No	Past	Present
Allergies				High Fevers			
Asthma				Hospitalization			
Bed wetting past age 5 yrs				Kidney Problems			
Cancer				Mastoiditis			
Cerebral Palsy				Measles			
Chicken Pox				Meningitis			
Cleft Lip or Palate				Motion Sickness			
Concussion				Mumps			
Cytomegalovirus (CMV)				Neurofibromatosis			
Developmental Delay				Noise Exposure			
Diabetes				Pneumonia			
Dizziness				RespSyncitial Virus (RSV)			
Ear Infections				Rubella			
Ear Surgery				Seizures			
Ear Tubes				Sinusitis (Chronic)			
Frequent Colds				Tinnitus			
Gastrointestinal Issues				Torticollis			
Head Trauma				Tuberculosis (TB)			
Headaches (Severe)				Vision Problems			
Hepatitis				Other: _____			

If you answered Past or Present to any of the above, please describe and list approximate dates:

_____
_____
_____
_____
_____

Has your child been diagnosed with any of the following developmental or learning disorders?

	No	Yes		No	Yes		No	Yes
Anxiety			Dyscalculia			Low Cognition		
Articulation Disorder			Dyslexia			Learning Disability		
Attention Deficits			Dysgraphia			Obsessive/Compulsive		
Autism			Executive Dysfunction			Reading Disability		
Behavior Disorder			Fine Motor Deficits			Sensory Integration		
Bipolar Disorder			Gross Motor Deficits			Visual Processing Disorder		
Depression			Language Disorder			Other: _____		

If yes, please explain: _____

Known Allergies or Dietary Restrictions: _____ ☐ None

Surgical History: _____ ☐ None

Has your child had any scans, x-rays, MRI's or special tests? ☐ Yes ☐ No

If yes, please list and provide results: _____

Current Medications and Dosages (Supplements, OTC and Prescription):

_____

Other Medical Concerns: _____ ☐ None

Hearing History

Was your child's hearing screened at birth? ☐ Yes ☐ No If yes, what were the results: _____

Do you have concerns about your child's hearing? ☐ Yes ☐ No If yes, please explain: _____

Does your child have a diagnosed hearing loss? ☐ Yes ☐ No If yes:

What type of hearing loss? Which ear(s)? _____

Wears amplification or an implant? ☐ Yes ☐ No If yes, type? _____

Preferential seating in the classroom? ☐ Yes ☐ No

Does your child have sound sensitivity? ☐ Yes ☐ No If yes, what type of reaction do they have to the offensive sound (fear, anger, pain, etc…)? _____

Family History

Do any immediate family members have the following conditions:

Condition	No	Yes		No	Yes
Anxiety / Depression			Hearing Loss from Birth		
Attention Deficit Disorder (ADD/ADHD)			Language Disorder		
Auditory Processing Disorder (APD)			Learning Disability		
Autism / Aspergers Spectrum Disorder			Migraines		
Bipolar Disorder			Obsessive/Compulsive Disorder (OCD)		
Cognitive Deficits			Sensory Integration (SI) Disorder		
Dyslexia			Other: _____		

If yes, please explain: _____

_____

_____

Developmental History

Were there any difficulties with feeding or latching on during the first 3 months of life? ☐ Yes ☐ No

Were there any delays in your child's early speech/language or motor development for the following skills:

Hold head erect _____ Crawl _____ Sit unsupported _____

Say first word _____ Walk alone _____ Toilet trained _____

Did your child crawl **on all fours** for at least 3 months and on time? ☐ Yes ☐ No _____

Do you consider your child clumsy? ☐ Yes ☐ No If yes, please explain: _____

Does your child struggle to transition from one surface type to another (ex: gravel to concrete, concrete to grass, etc…):

☐ Yes ☐ No If yes, please explain: _____

Does your child have any muscle tone or strength issues? ☐ Yes ☐ No If yes, please explain: _____

Can your child distinguish right from left? ☐ Yes ☐ No Did your child struggle to pick a dominant hand: ☐ Yes ☐ No

Does your child play/interact well with other children? ☐ Yes ☐No Please explain: _____

_____

Do you consider your child to be needy or clingy? ☐ Yes ☐ No _____

Does your child struggle to sit still and/or pay attention? ☐ Yes ☐ No _____

Does your child struggle to tie shoes or fasten snaps or buttons? ☐ Yes ☐ No _____

Does your child reverse letters in writing? ☐ Yes ☐ No Is their handwriting poor or labored? ☐ Yes ☐ No

Does your child write with a head tilt or unusual pen/pencil grasp? ☐ Yes ☐ No _____

Can your child catch a ball? ☐ Yes ☐ No Any hand/eye coordination concerns? ☐ Yes ☐ No _____

Does/did your child struggle to ride a bike, skate, swim, or swing? ☐ Yes ☐ No _____

Does your child speak another language and/or is another language spoken in the home? ☐ Yes ☐ No

If yes, please list: _____

Previous Testing

Evaluation	*Approximate Date*	*Where/By Who?*	*Brief Summary of Results*
Speech/Language Evaluation			
Occupational Therapy Evaluation			
Visual Processing Evaluation			
Psychological, Psych-Ed, or Neuro-Psychological Evaluation			
Auditory Processing Evaluation			
Other: _____ _____			

Educational History

Current School: _____ ☐ Home schooled ☐ Private ☐ Public

Current Grade Level: _____ ☐ Pre-school ☐ Day care

Does your child have any academic weaknesses: ☐ N/A (for toddlers)

None Reading Science Social Studies
Math Writing Spelling Other: _____

Explain: _____

Is your child enrolled in any current tutoring, therapy or special services in or out of school? (include start dates and frequency)? _____

Does your child have a current IEP? ☐ Yes ☐ No If yes, please explain: _____

Please list your child's extra-curricular activities and favorite toys: _____

Learning style (check all that apply): ☐ N/A (for infants and toddlers)

☐ Logical	☐ A planner	☐ Creative	☐ Spontaneous
☐ Analytical	☐ Good sense of time	☐ Intuitive	☐ No sense of time
☐ Sequential	☐ Good fine motor skills	☐ Scattered	☐ Good gross motor skills
☐ Detail oriented	☐ Rule oriented	☐ Disorganized	☐ Thinks outside of the box

Is there anything else about your child's educational needs that we should know? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Communication/Social Skills Difficulties

Communication difficulties (check all that apply): ☐ None

☐ Unclear speech	☐ A need for messages to be repeated	☐ Frustration with communication
☐ Localization difficulties	☐ Auditory sequencing weaknesses	☐ Misinterpretation of messages
☐ Attention weaknesses	☐ Auditory memory weaknesses	☐ (Other)_____

_____

_____

Social difficulties (check all that apply): ☐ None

☐ Impulsive	☐ Frustrations	☐ Distressed by loud sounds	☐ Disobedient
☐ Destructive	☐ Nightmares	☐ Difficulty making/keeping friends	☐ Difficulty sleeping
☐ Temper tantrums	☐ Fearful	☐ Over-sensitivity to touch, light, or fabrics (circle all that apply)	
☐ Aggressive	☐ Shy	☐ Thumb/finger sucking	☐ (other) _____

_____

_____

Is there anything else we need to know about your child? _____

_____

_____

_____

_____ _____

Print name of person completing this form Relationship to patient

_____ _____

Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RELEASE OF INFORMATION FORM

You may refuse to sign this acknowledgement & authorization, however in doing so we may not be able to proceed with treatment.

How should our staff address you (parent/guardian or patient if 18 or older)? _____

By signing, you acknowledge receipt of a copy of the currently effective Notice of Privacy Practices (NOPP) for Little Listeners. Your signature verifies that you have reviewed this NOPP and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. Further, you acknowledge that Little Listeners reserves the right to change the terms of the NOPP from time to time and that you may contact Little Listeners at any time to obtain an updated copy. A copy of this signed, dated document shall be as effective as the original.

The policy at Little Listeners regarding **written** health information access, restricts that access to the individual (patient or guardian) signing this document. Reports and written communications with confidential information will be delivered via the email address provided in the case history and through our secure/encrypted email server to this single individual only. We ask that any other requests from other professionals involved in your (or your child's care) be handled between you and that professional directly with the electronic copy that we send directly to you. We will not be able to send personal written information via any other electronic format or to any other professionals without your specific and directed consent outside of this form. Consent can be grated either by handwritten or email communication and by specifically designating the written information to be shared and an email address or fax number to whom we may send the information securely.

The **verbal** information policy at Little Listeners regarding collaborative services for you or your child with Speech and Language Pathologists, Occupational Therapists, BCW Service Coordinators and Staff, Psychologists, Educators, Tutors, Physicians and or authorized business office personnel for those professionals is authorized by my signature below unless specifically excluded as the following:

_____

By signing this form, you consent to being contacted by the phone numbers or email addresses provided in the case history regarding appointments, treatment, billing or specific health information.

If you prefer to opt out of updates from our clinic regarding special services, events, or fund raising efforts, please initial here. _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Little Listeners is a non-discriminating company that will not refuse services based on cultural, religious or language differences. In the event of a language barrier, interpretation services will be provided to the client/family at our expense. We do, however reserve the right to refuse services if we feel as if a client/family is a threat to our staff, clients or other families within our facility, or if it is our judgment that our services may not be beneficial to you or your child.

It is your right to submit a complaint regarding our compliance with the HIPAA Omnibus Rule or State/Federal laws. You may request a form from us to complete or download a form at http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html

_____	_____	_____
Please ***print*** name of Patient	Patient ***signature*** (if 18 years or older)	Date
_____	_____	_____
Please ***print*** name of Guardian	Guardian ***signature*** (if patient under 18)	Date

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Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____ _____

_____

Signature of Privacy Officer

FINANCIAL POLICY

Updated 01/11/2019

Little Listeners, LLC is out-of-network for all private insurance companies. Little Listeners, LLC charges the usual and customary rate for assessment and therapy services. There is a $25 service fee for all returned checks. ***Full payment is due at the time of service.***

I have read and understand the above insurance and billing policies.

Signed _____ Date _____

Parent/ Legal Guardian Relationship

CONSENT FOR TREATMENT

I, _____ (parent/legal guardian), knowing that _____ (child's name) has a diagnosis requiring audiological testing or hearing therapy, voluntarily consent to such care for the aforementioned child by the therapist doing business for Little Listeners, LLC as may be beneficial in the professional judgment of this child's therapist. I consent to care and treatment that falls within the scope of practice as defined by the State of Georgia for each discipline.

I acknowledge that I am responsible for making the patient's therapist and/or the staff of Little Listeners, LLC aware of any changes in my child's physical or mental status that may influence my child's plan of care. I understand that treatment will involve physical participation on the part of the patient which may involve risks of injury. I further understand that Little Listeners, LLC regularly utilizes a therapy dog on the premises and that it is my sole responsibility to provide Little Listeners, LLC with written notice if the patient or any party present during treatment has any allergy, fear, or other circumstance that would require separation from the therapy dog. I acknowledge that animals are inherently unpredictable, and I agree to indemnify and hold harmless Little Listeners, LLC, Little Listeners staff, and Little Listeners volunteers from any harm or injury arising from contact with the therapy dog.

I understand that I am solely responsible at all times for the supervision and conduct of my child while visiting Little Listeners. I agree that I will indemnify and hold harmless Little Listeners, LLC, Little Listeners staff, and Little Listeners volunteers for any liability arising from my conduct, my party's conduct, or my child's conduct while at Little Listeners or from my failure to adequately supervise my child during therapy or testing. I acknowledge that no guarantee has been made to me as the results of evaluation or treatment. I understand that Little Listeners, LLC is a teaching facility and that supervised students or volunteers may participate in my child's treatment session.

In my absence, I consent that_____ (child's name) may receive therapy under the care of:

_____.

(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

_____ can or _____ can not receive updates on my child's progress.

Signed _____ Date _____

Parent/Guardian Relationship

MEDIA RELEASE

I ___ do / ___ do not consent to the use of photos or videos of myself or my child to be used by Little Listeners, LLC on social media or in marketing materials for the purposes of business development and/or business marketing.

Signed _____Printed Name_____ Date _____