Loudoun Pediatric Speech Services

loudounspeech@gmail.com
Phone: 703-508-3777

Client Intake Form

Child's Name: Today's Date:
DOB: Parents Names:
School/Grade Level: Address:

Home Phone:
Cell Phone:
Email:

Referred by:

Pediatrician: Contact Info:

Father's Occupation: Mother's Occupation:

Siblings (ages):

Additional relatives living in the home:

Language(s) spoken in the home:

Prenatal and Birth History

Mother's General Health During Pregnancy (illness, medications, etc)

Length of Pregnancy: Apgar Scores at Birth:

Type of Delivery: Head First Feet First Breech Cesarean

Complications at Birth:

Child's Medical History

Please denote the age of occurrence and frequency if applicable:

*Allergies:	Asthma:	Chicken Pox
Colds:	Headaches:	Ear Infections:
High Fever:	Pneumonia:	Meningitis:
Sinusitis:	Seizures:	

Other known medical diagnoses:

Surgical or Hospitalization History:

Previous and Current Medications:

*Additional Food Allergies:

Child's Developmental History

Provide the approximate age (months) at which each activity began:

Crawl_____ Sit-up_____ Stand_____ Walk_____

Sippy Cup Drinking_____ Open Cup Drinking_____

Baby Foods_____ Table Foods_____ Self-Feeding_____

Babbling_____ Single Words_____ Combining Words_____

Requesting_____ Answering simple yes/no, what questions_____

Ask simple questions_____ Engage in conversation_____

At what age did the use of pacifier cease?_____

Are there any known delays or disorders affecting your child's development?

Are there or have there ever been any feeding problems (sucking from bottle, swallowing, excessive drooling, chewing)?

Would you consider your child a picky eater? If so, explain.

Treatment History

Has the family received consultation or evaluation from a developmental pediatrician, neurologist, or other therapist? If so please describe and fax a copy of any related reports.

Is your child currently receiving speech and language, occupational, or other services? If so please describe the origination, nature, and frequency.

Please take a few moments to "paint a picture" of your child today. Describe a typical day, including the activities and your child's responses to them. Explain how your child communicates his desires and needs, any significant behaviors or difficulties that impede his daily life.

Now list the three things you would most like to see your child doing in the next year.

Last, please list your greatest concerns regarding child's communication and overall development.

Patient Financial Insurance Responsibility Form for In-Network Patients Only

AS A COURTESY, Loudoun Speech Services, LLC will verify your coverage and bill your insurance on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible / coinsurance as determined by your contract with your insurance carrier. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim or if you elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Loudoun Speech Services, LLC for providing treatment to the above named patient. I certify that the information provided is, to the best of my knowledge, true, and accurate. I authorize my insurer to pay any benefits directly to Loudoun Speech Services, LLC

A $25.00 FEE will be charged for all returned checks.

Printed Name: _____ Signature: _____
Date: _____

Insurance Information:

Insurance Name: _____

Claims Address: _____
_____

Employer Group Plan: _____ or Individual Plan: _____

Policyholder Name: _____
Policy Name DOB: _____
Policyholder SSN: _____
Group # _____