Michelle Jenschke, M.S., CCC-SLP
5601 S.Padre Island Dr., Ste. D #147
Corpus Christi, TX 78412

SIMPLY SPEECH
Speech/Language Therapy

Phone: 361.792.0822
Fax: 361.288.4109
michelle@simplyspeechtx.com

Patient Information

Name: _____ Today's Date: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Preferred contact method:

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Patient's Occupation: _____

Patient's Employer: _____

Parent/Spouse's Name: _____

Parent/Spouse's Employer: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____

Address (if different from patient address): _____

Phone number (if different from patient phone): _____

How did you hear about this practice?

☐ Doctor_____

☐ Friend/Family Member_____

☐ Google

☐ Other_____

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Insurance Information

Please give the receptionist a copy of your insurance card

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

_____
Name of Person Completing This Form

_____
Relationship to Patient

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Authorization for Release of Information

I give Simply Speech permission to use or share my health information with:

_____

The information that will be used or shared includes (check all that apply):

- ☐ My medical records
- ☐ My treatment records (progress notes, daily records)
- ☐ My speech, language, or swallowing test results
- ☐ Other: _____

This information is being used or shared because:

_____

This authorization will expire:

- On _____ (date)
- After the following event happens: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to Michelle Jenschke at 5601 S. Padre Island Dr./ Corpus Christi, TX 78412 to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____ _____

Print Patient's Name | Date

_____ _____

Patient or Parent/Guardian Signature | Relationship to Patient

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Attendance Policy

Thank you for choosing Simply Speech. We want to provide the best possible services to all of our patients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to your/your child's success. We ask that you follow the attendance policies outlined below:

1. **Cancellations:** Please call us at least 24 hours in advance to cancel your appointment. A fee of $20.00 will be charged if we are not given 24 hours' notice. Insurance will not cover this fee.
2. **Missed Appointments:** If you cancel or do not attend 3 sessions in a row, we will put your services on hold until scheduling problems can be worked out. Dismissal from services will occur if there are 3 no show appointments. An 80% attendance rate is expected. Please do not schedule other appointments when speech therapy is scheduled. If the rate of attendance drops below 80%, services will be on hold (or discharged) until the attendance policy can be adhered to.
3. **Late for Appointments:** If you are more than 15 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). If you are late for 3 or more sessions, we may put your services on hold until scheduling problems can be worked out.
4. **Clinician Cancellations:** If your speech-language pathologist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

To cancel an appointment, call Michelle at (361) 792-0822

☐ I agree to the attendance policies outlined above.

Print Patient's Name _____ Date _____

Patient or Parent/Guardian Signature _____

Relationship to Patient _____

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Treatment Authorization

I agree to allow Michelle Jenschke, SLP to provide speech-language pathology services for myself or my child. In addition:

- ☐ I have seen and agree with the treatment goals and therapy plan.
- ☐ I agree to attend scheduled therapy sessions (see attendance policy).
- ☐ I agree to participate in my child's/loved one's treatment, as appropriate.
- ☐ I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.
- ☐ I understand that I am responsible for 100% of fees due for services, regardless of whether or not I am reimbursed by my insurance company. Payment is due no later than time of service.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient

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Patient History – Child

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Person Completing This Form: _____

Relationship to Client: _____

Mother's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Occupation: _____

Employer: _____

Education Completed: _____

Father's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Occupation: _____

Employer: _____

Education Completed: _____

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List all children in the family from oldest to youngest

Name	Age	Sex	Grade in School	General Health

Does anyone else in the family have speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please describe: _____

Who referred you for the evaluation? _____

Child's pediatrician or family doctor _____

Address _____

Other doctor(s) treating the child _____

Has the child had any previous testing or therapy for speech, language, or hearing problems?
☐ Yes ☐ No

If yes, name of agency and date tested _____
(Please request that copies of all test results be sent to our office)

Why are you bringing your child to see us today?

_____

_____

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BIRTH HISTORY

Weight of child at birth _____ Was the child full term? ☐ Yes ☐ No

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Type of birth:

☐ Normal ☐ Induced ☐ Forceps ☐ Caesarean ☐ Premature; How many weeks _____?

Were there any physical deformities or malformations observed at birth (such as "blueness," jaundice, abnormal shape of head)? ☐ Yes ☐ No

If yes, please describe: _____

DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets)? ☐ Yes ☐ No

If yes, please describe: _____

Give ages of development for the following behaviors:

Sitting unsupported	_____	Walking	_____
Eating solid foods	_____	Self-feeding	_____
Crawling	_____	Self-dressing	_____
Standing alone	_____	Bladder/bowel control	_____

Do you feel that the child was late or had difficulty in the development of these behaviors?

☐ Yes ☐ No

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MEDICAL HISTORY

Date and type of last medical examination _____

List ages for any of the following childhood diseases:

Whooping cough _____ Pneumonia _____

Mumps _____ Chicken Pox _____

Measles _____ Tonsillitis _____

Rheumatic fever _____ Other: _____

Were there any complications with any of the above, such as high/persistent fevers, convulsions, or persistent muscle weakness? ☐ Yes ☐ No

If yes, please explain: _____

Is the child subject to frequent colds, sore throats? ☐ Yes ☐ No

Has the child had allergies, hay fever, etc.? ☐ Yes ☐ No

If yes, please describe: _____

Does the child tend to breathe with mouth open? ☐ Yes ☐ No

Has the child had any operations? ☐ Yes ☐ No

If yes, please describe: _____

Has the child had tonsils and adenoids removed? ☐ Yes ☐ No

If yes, when? _____

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? ☐ Yes ☐ No

If yes, please describe: _____

Has hearing been tested? ☐ Yes ☐ No If yes, when? _____

Results: _____

Has the child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? _____

If yes, does the child still have ear (PE) tubes? ☐ Yes ☐ No

Has the child ever worn eyeglasses or had any difficulty with eyes? ☐ Yes ☐ No

If yes, please describe: _____

Does the child have any dental problems? ☐ Yes ☐ No

If yes, please describe: _____

Has the child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

_____

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EDUCATION HISTORY

Current School _____

Address _____

City _____ State _____ Zip _____

Grade _____ Teacher _____

Did the child attend nursery school? ☐ Yes ☐ No

If yes, when? From age _____ to age _____

At what age did the child attend kindergarten? _____

Does the child like school? ☐ Yes ☐ No

Does the child like the teacher? ☐ Yes ☐ No

Describe performance in school (please note strong and weak areas)

_____

_____

_____

Does the child attend any special classes (such as speech therapy, language development, reading, resource room, special education classroom)? ☐ Yes ☐ No

If yes, please describe:

_____

_____

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DAILY BEHAVIOR

Where does the child usually play? _____

Are there children close to the child's age in the neighborhood? ☐ Yes ☐ No

Does the child prefer to play alone? ☐ Yes ☐ No

Does the child prefer to play with older or younger children? _____

Does the child have a close friend? ☐ Yes ☐ No

What are your most frequent discipline problems with this child?

_____

_____

Who does the disciplining? _____

How do you discipline?

_____

_____

What does the child do well?

_____

_____

What does the child have trouble doing?

_____

_____

Does the child have difficulty concentrating? _____

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COMMUNICATION HISTORY

Is the child's speech understandable to you? ☐ to friends? ☐ to strangers? ☐ to other family members? ☐

List sounds or words that the child has trouble saying

How does the child compare with siblings in speech development?

Does the child use words in meaningful ways for his/her age? ☐ Yes ☐ No

Give examples of sentences the child uses by himself/herself (not sentences that are repeated after you):

At what age did the child babble? _____ say first words? _____

put two words together in a sentence? _____ use three-word sentences? _____

Does the child seem to understand directions? ☐ Yes ☐ No

Does the child prefer to use speech or gestures when communicating?

Do you have any further questions?

_____
Patient or Parent/Guardian Signature

_____
Relationship to Patient

_____
Date

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Acknowledgment That You Have Received Our HIPAA Privacy Notice

Simply Speech is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient