Women & Children
HUNTSVILLE HOSPITAL

PEDIATRIC THERAPY & AUDIOLOGY CASE HISTORY FORM

Child's Name: _______________________________________ **Date of Birth:** ___________________ **Age:** ________________

Preferred Name or Nickname: ____ **( ) Male ( ) Female**

Referring Physician: ___________________________________ **Services Requested: ( ) PT ( ) OT ( ) ST ( ) Audiology**

Diagnosis ____

Is your child currently receiving therapy services? ( ) Yes ( ) No What Type? ( ) PT ( ) OT ( ) ST

If yes, where are they receiving therapy? ____

Family Information

With whom does the child live? (provide names) ____

Parents/Guardian phone numbers____

Home Address ____

Does he/she have brother and sisters? ( ) Yes ( ) No Age of sibling(s):__________________________________

Medical History

Type of Delivery: ( ) Vaginal Delivery ( ) C-section ( ) Vacuum ( ) Forceps

Length of pregnancy ( ) Full term, __________weeks ( ) Pre-term, __________weeks

Any complications or infections (for example: CMV, herpes, rubella, syphilis, toxoplasmosis) during pregnancy or delivery? ____

____

Following birth, did the baby have difficulty, require extended hospitalization, special testing, or surgery?

____

____

Since birth, has the child been hospitalized or had surgery? ( ) Yes ( ) No

If yes, please list age at time of admission and reason for admission and any surgery done:

Date	Reason for Hospitalization	Surgery

Patient Label

Has your child ever been diagnosed with any of the following conditions?

( ) Cleft lip ( ) Cleft Palate ( ) Both cleft lip and cleft palate
( ) Hydrocephaly ( ) Microcephaly ( ) Macrocephaly
( ) Encephalitis ( ) Meningitis ( ) Cytomegalovirus (CMV)
( ) Contagious Diseases (Please include common childhood diseases) ______________________________________
( ) Asthma ( ) Sinus/Allergies: If yes, specify: ___________________________________
( ) Other Respiratory problems: If yes, specify: ____
( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: _____________________________________
( ) Spina Bifida ( ) Autism/PDD________________ ( )Attention Deficit
( ) Cardiac (heart) problems: Specify: ____
( ) Pacemaker ( ) Defibrillator
( ) Failure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: _____________________
( ) Cancer: Specify: ____
( ) Diabetes ( ) Blood disorder ____
( ) Genetic Syndrome: If yes, specify: ____
( ) Orthopedic injuries (ex: broken bones) Specify: ____
( ) Joint Condition/Arthritis ( ) Torticollis ( ) Skin Condition ________________________
( ) Pregnant ( ) Lactating
( ) Other____

Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time? ______________________

Is your child on medication for the seizures? ( ) Yes ( ) No

Has your child ever had special testing done for the seizures? ( ) Yes ( ) No

If yes, what testing was done? ____

What were the results of the testing? ____

Developmental History

At what age did your child: First roll over? ____________________________________

Sit with assistance? _______________________________ Sit alone? ____

Crawl? ____ Pull to Stand? _____________________________________

Cruise furniture? __________________________________ Walk? ____

Hold items with two hands? ________________________ Pick things up? ___________________________________

Reach to get what they want? _______________________

Babble? (ex. Baba, awaba, etc.)______________________ Use of variety of sounds in play? _____________________

Say first word? ___________________________________ Combine words? __________________________________

Is your child toilet trained? ( ) Yes ( ) No If yes, at what age: ____

Please list your child's favorite toys ____

Feeding/Swallowing

Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long? ________________________

What kind of diet is your child currently on? ____

Does your child feed him/herself? ( ) Yes ( ) No Eat with assistance ( ) Yes ( ) No

Does your child have any suspected swallowing problems? ( ) Yes ( ) No

Does your child have any known swallowing problems? ( ) Yes ( ) No

Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No

If yes, please specify ____

Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No

Does your child require skilled nursing care in the home? ( ) Yes ( ) No

Patient Label

Does your child have any vision problems? ( ) Yes ( ) No

If yes, please clarify: ____

Hearing History

Do you have any concerns about your child's hearing? ( ) Yes ( ) No

If yes, please explain: ____

Is there a family history of hearing loss? ( ) Yes ( ) No

If yes, please explain: ____

Does your child have a history of acute or chronic otitis media (ear infections)? ( ) Yes ( ) No

If yes, has your child ever had "tubes"? ( ) Yes ( ) No

If yes, how old was your child when they were placed? ______________________

Has your child's hearing been screened or tested before? ( ) Yes ( ) No

If yes, when was the testing completed and what were the results? ______________________

____

If treatment or follow-up was recommended, please describe: ______________________

____

Communication Needs

Do you or your child have any special communication needs?

Child: ____

Caregiver: ____

What is your preferred language?

Child: ______________________ Caregiver: ______________________

Learning Profile

Do you or your child have any barriers to learning? (ex. Visual, hearing, language, or mental impairments?)

Child: ____

Caregiver: ____

How do you feel your child learns best? ( ) visualization ( ) verbal instruction ( ) demonstration

How does caregiver learn best? ( ) visualization ( ) verbal instruction ( ) demonstration

Does your child attend school or daycare? If so, what type and are there any special services provided?

____

Does the child or caregiver have any limitations in mobility (ex. Use a wheelchair, crutches, or have difficulty moving?)

Child: ____

Caregiver: ____

Family Goal for Evaluation/Treatment: ____

____

Person completing Form: ______________________ **Relationship to Child:** ______________________

Signed: ______________________ **Date:** ______________________

Information reviewed and verified by clinician____

Clinician signature/date/time

Patient
Label

Women Children
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PEDIATRIC THERAPYAND AUDIOLOGY
MEDICATIONS AND ALLERGIES

Patient's Name: ______________________ **Date of Birth:** ______________ **Age:** ____________

Current Medications:

Medication Name	Dose	Route (by mouth, etc)	How often	Reason

Does your child have any allergies? ( ) yes ( ) no

If returning patient, are there any new allergies? ( ) yes ( ) no

Allergy	Reaction	Severity (mild, moderate, critical, unknown)
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown

Person completing Form: ______________________ **Relationship to Patient:** ______________________

Signed: ______________________ **Date:** ______________________

Information reviewed and verified by clinician: ______________________
Clinician signature/date/time

Patient
Label

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PEDIATRIC AUDIOLOGY POLICIES

(256) 265-7952 phone, (256) 265-7953 fax

Patient Label

Supervision: An adult must accompany all children to their appointments. **If a child is under 14 years old or has developmental delays, an adult must remain on the premises during the child's appointment.** Our staff may ask a parent to stay for other reasons at their discretion.

A **parent or legal guardian** must be present to sign consent for testing/treatment on the patient's initial visit. We cannot provide testing or treatment without legal consent.

Siblings: While siblings may attend sessions, it is not recommended. If siblings do attend sessions, they must either be able to sit quietly during testing or wait in the reception area *with an adult*. If the audiologist's attention cannot remain focused on the child being tested or quiet test conditions cannot be maintained, testing may need to be rescheduled. Again, please remember that all children must be supervised by an adult at all times.

Tardiness: Every effort is made to see patients in a timely manner. You can help. Please arrive in time to complete the registration process and begin testing at your child's appointment time. Patients arriving more than 10 minutes after their appointment will be seen only if the audiologist's schedule permits. Rescheduling may be required.

Cancellations: We understand that, from time to time, there will be reasons you must cancel your appointments (illness, car trouble, out of town, etc.). We ask that you call our office as soon as possible so we may accommodate other patients. **A call less than an hour prior to your appointment time will be counted as a "no show."**

No Shows: Should you fail to show for a scheduled appointment, it will be documented in your child's chart and a letter may be sent to your child's physician.

Scheduling Holds: "No shows" and excessive tardiness or cancellations can negatively impact not only your child's care, but also the care of other children. Therefore, patients will be placed on a scheduling hold for 6 months if they (a) fail to show for 2 consecutive appointments or (b) have a total of 3 "no shows," late arrivals, or cancellations in any combination over a 6-month period. A letter will be sent to your child's physician, notifying them of this action. Additional appointments will not be scheduled for your child until the scheduling hold has expired. This policy is necessary to best serve all patients in need of audiologic care.

Inclement weather: Pediatric Audiology follows Huntsville City Schools closings and delayed openings for inclement weather. If they close or open late due to weather, we will do the same. This is for **WEATHER ONLY**.

Insurance Coverage: Please call your insurance carrier. Some insurance carriers require prior authorization and/or pre-admission certification for audiology testing and procedures. If this is required and not done, they can refuse to pay for services. Some insurance carriers may have a limited amount of, or no, coverage for audiology procedures or hearing devices. You will be responsible for payment for services not covered by your insurance.

I have read and understand the above policies.

___________________________ ___________________________
Patient's Representative Date

___________________________ ___________________________
Audiologist Date/Time

AUDITK

Rev: 19-JAN 2016