Keystone
Pediatric Developmental Center
a service of Keystone Health

Dear Family,

Welcome to Keystone Pediatric Developmental Center. Thank you for scheduling an evaluation with us. The following information is important to read prior to your appointment.

1. Please make sure you complete the intake packet prior to your scheduled appointment.
2. Your child's evaluation should take about 1½ to 2 hours, depending on your child's age and the amount of standardized testing needed. In most cases, parents are asked to "sit in" with us, so that you can observe and so your child will feel more comfortable.
3. Please wear comfortable clothing on your child so they can participate in any physical activities that may occur.
4. You may bring a small snack if you think your child might need one, during or at the conclusion of their evaluation.
5. All of our therapists are experts in handling children; so much of the process involves toys and fun equipment. Most children thoroughly enjoy themselves.

Completed packets can also be:

Mailed to:
Keystone Pediatric Developmental Center
111 Chambers Hill Drive, Suite 101
Chambersburg, PA, 17201
(At least 1 week prior to scheduled appointment)

Faxed to: (717) 261-4725

We look forward to meeting with you and your child. Please give us a call at (717) 709-7997 if you have any questions

PATIENT REGISTRATION

Patient Information

Name: _____
First *Middle* *Last*

Address: _____

Social Security Number: _____Home phone: (____)_____ Cell Phone: (____)_____

Date of Birth: _____ Marital Status: _____ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information (Complete this section for a patient less than 18 years old)

Mother's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Father's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

_____/_____
Address *Phone*

Person Responsible for Payment (Complete this section for a patient less than 18 years old)

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____Telephone:_____

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone :_____(you will receive a text message)

E-mail:_____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This Permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

(Patient's 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

7/30/18 ksw

PERMISSION FOR TREATMENT OF
CHILDREN

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____

Name of Parent/Legal Guardian: _____

If I can't bring my child to a medical/behavioral health or dental appointment, I give permission for the person(s) listed below to go with my child to visits at Keystone Health Center. He/she can also approve treatment for my child during the visit, including shots and minor dental and medical procedures.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Please Note: Sometimes, the provider may decide that a parent must be present for certain dental procedures: Extractions, Root Canal's, Surgical procedures, Nitrous visits and Operating Room visits.

This permission remains in effect until revoked in writing.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

_____
Staff Initials

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Speech/Language History Form--Child

Child's Name:_____Birthdate:_____Date Completed:_____
Parent 1:_____ Parent 2:_____
Sibling names and ages: _____

_____

Referring Provider:_____
Current Medical Conditions: _____

_____

Current Medications: _____

_____

Allergies:_____
Family History: Is there family history of:
Speech/Language Difficulties Yes/No Hearing Impairment/Deafness Yes/No
Learning Difficulties Yes/No Developmental Difficulties Yes/No
If yes to any of the above, please describe_____

_____

Developmental History:
Was there anything unusual about the pregnancy or birth? Yes/No
If yes, please explain_____

_____

Please provide the age your child reached the following milestones:
____Sat alone ____Crawled ____Walked ____Completed toilet training
____Babbled ____Said first word(s) ____Combined 2 words ____Spoke in short sentences
Does your child receive any other therapy through another provider? (Ex: school, Intermediate unit)
____ST ____OT ____PT ____Behavioral ____Vision
Please explain: _____

_____

Speech and Language Development:
How does your child prefer to communicate (please check)?
____gestures ____words ____phrases ____sentences ____sign language ____communication device
Was your child's speech/language development progressing normally then stop or regress? Yes/No
Is your child's speech difficult to understand? Yes/No
What speech sounds does s/he have difficulty pronouncing? _____

_____

Your child's voice is: ____normal ____hoarse ____too high ____too low ____too loud ____too soft
Does your child stutter? Yes/No Does your child echo words/phrases? Yes/No
Does your child: Identify objects? Yes/No Understand actions (verbs)? Yes/No
Ask questions? Yes/No Understand what you are saying? Yes/No
Follow directions? Yes/No Respond correctly to yes/no questions? Yes/No
Respond correctly to "Wh" (who, what, where, etc.) questions? Yes/No
Has your child ever receive a speech/language evaluation? Yes/No Date_____Where?_____
Has your child received speech/language therapy previously? Yes/No When?_____How long?____
Please describe your current concerns about your child's speech/language:_____

_____

_____

Is your child aware of/frustrated by any speech/language difficulties? Yes/No Describe_____

_____

What do you see as your child's most difficult problem at home?_____

_____

Does your child have cleft lip or palate? Yes/No
Has your child had feeding/eating difficulties (biting, choking, swallowing, chewing)? Yes/No
If yes, please explain:_____

_____

Does your child put toys in mouth? Yes/No Drool? Yes/No Feed self with utensils? Yes/No
Does your child have food allergies? Yes/No
If yes, please explain:_____

_____

Does your child have strong food preferences/aversions? Yes/No
If yes, please explain:_____

_____

Does your child brush his/her teeth and/or allow brushing? Yes/No
If no, please explain:_____

_____

Behavioral Characteristics: Please check the ones below which describe your child:

___cooperative	___separation difficulties	___willing to try new activities
___attentive	___restless/overactive	___plays alone for reasonable length of time
___stubborn	___destructive/aggressive	___easily frustrated/impulsive
___poor eye contact	___inappropriate behavior	___easily distracted/short attention span
___withdrawn	___self-abusive behavior	___repetitive actions (spinning, jumping, etc.)

Favorite Activities:
Please list your child's favorite activities, hobbies, toys, games, etc_____

_____

School History:
Name of school:_____Grade:_____
What are your child's strengths and/or best subjects?_____

_____

Is your child having difficulty with particular subjects? Yes/No If yes, which?_____

_____

Is your child receiving help at school or home (support services, tutoring, etc.)? Yes/No
If yes, please explain:_____

_____

Other:
Date of last hearing screening/test:_____Results:_____
Date of last vision screening/test:_____ Results:_____
Is there any other information you feel the speech therapist should know about your child (serious medical condition, custody arrangements, fears, etc.)? _____

_____

_____

_____

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

<u>Race</u>- relates to a persons appearance such as skin color:

□ **White/Caucasian** □ **Black/African American**

□ **Asian** □ **American Indian**

□ **Native Hawaiian** □ **Other Pacific Islander**

<u>Ethnicity</u>- relates to nationality and culture:

□ **Latino(a) / Hispanic**

□ **Non-Latino(a)**

Family Size	Annual Family Income			
1	☐ up to $13,590	☐ $13,591 to $20,385	☐ $20,386 to $27,180	☐ $27,181 and above
2	☐ up to $18,310	☐ $18,311 to $27,465	☐ $27,466 to $36,620	☐ $36,621 and above
3	☐ up to $23,030	☐ $23,031 to $34,545	☐ $34,546 to $46,060	☐ $46,061 and above
4	☐ up to $27,750	☐ $27,751 to $41,625	☐ $41,626 to $55,500	☐ $55,501 and above
5	☐ up to $32,470	☐ $32,471 to $48,705	☐ $48,706 to $64,940	☐ $64,941 and above
6	☐ up to $37,190	☐ $37,191 to $55,785	☐ $55,786 to $74,380	☐ $74,381 and above
7	☐ up to $41,910	☐ $41,911 to $62,865	☐ $62,866 to $83,820	☐ $83,821 and above
8	☐ up to $46,630	☐ $46,631 to $69,940	☐ $69,941 to $93,260	☐ $93,261 and above
9	☐ up to $51,350	☐ $51,351 to $77,025	☐ $77,026 to $102,700	☐ $102,701 and above
10	☐ up to $56,070	☐ $56,071 to $84,105	☐ $84,106 to $112,140	☐ $112,141 and above