



Keystone Pediatric Therapies

a service of Keystone Health

Dear Family,

Welcome to Keystone Pediatric Therapies. 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 1 to 2-½ 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. We evaluate babies in their diapers. For toddlers or older children, we ask that you bring gym shorts, a bathing suit, or a leotard.
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 Therapies
3583 Scotland Rd.
Scotland, PA, 17254
(At least 1 week prior to scheduled appointment)

Faxed to: (717) 446-0707

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:



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

Date

Staff Initials



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

Speech/Language History Form--Child

Child's Name: _____ Birthdate: _____ Date Completed: _____

Mother: (Dr/Mrs/Miss/Ms) _____ Father: (Dr/Mr) _____

Sibling names and ages: _____

Referring Provider: _____

Current Medical Conditions: _____

Current Medications: _____

Hospitalizations & Surgeries: _____

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? _____

Oral Motor and Feeding History:

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: _____

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

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.

Race- relates to a persons appearance such as skin color:

- White/Caucasian**
 Black/African American
 Asian
 American Indian
 Native Hawaiian
 Other Pacific Islander
 Multi-racial

Ethnicity- relates to nationality and culture:

- Latino/Hispanic**
 Non Latino

Do you live in public housing:

- Yes**
 No

Family Size	<u>Annual Family Income</u>		
1	<input type="checkbox"/> \$12,140 and below	<input type="checkbox"/> \$18,210 and below	<input type="checkbox"/> \$24,280 and below
	<input type="checkbox"/> \$24,281 and above		
2	<input type="checkbox"/> \$16,460 and below	<input type="checkbox"/> \$24,690 and below	<input type="checkbox"/> \$32,920 and below
	<input type="checkbox"/> \$32,921 and above		
3	<input type="checkbox"/> \$20,780 and below	<input type="checkbox"/> \$31,170 and below	<input type="checkbox"/> \$41,560 and below
	<input type="checkbox"/> \$41,561 and above		
4	<input type="checkbox"/> \$25,100 and below	<input type="checkbox"/> \$37,650 and below	<input type="checkbox"/> \$50,200 and below
	<input type="checkbox"/> \$50,201 and above		
5	<input type="checkbox"/> \$29,420 and below	<input type="checkbox"/> \$44,130 and below	<input type="checkbox"/> \$58,840 and below
	<input type="checkbox"/> \$58,841 and above		
6	<input type="checkbox"/> \$33,740 and below	<input type="checkbox"/> \$50,610 and below	<input type="checkbox"/> \$67,480 and below
	<input type="checkbox"/> \$67,481 and above		
7	<input type="checkbox"/> \$38,060 and below	<input type="checkbox"/> \$57,090 and below	<input type="checkbox"/> \$76,120 and below
	<input type="checkbox"/> \$76,121 and above		
8	<input type="checkbox"/> \$42,380 and below	<input type="checkbox"/> \$63,570 and below	<input type="checkbox"/> \$84,760 and below
	<input type="checkbox"/> \$84,761 and above		
9	<input type="checkbox"/> \$46,700 and below	<input type="checkbox"/> \$70,050 and below	<input type="checkbox"/> \$93,400 and below
	<input type="checkbox"/> \$93,401 and above		
10	<input type="checkbox"/> \$51,020 and below	<input type="checkbox"/> \$76,530 and below	<input type="checkbox"/> \$102,040 and below
	<input type="checkbox"/> \$102,041 and above		