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 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 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: _____
(First) (Middle) (Last)

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

(Patients 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

2/14/19 ksw

PERMISSION FOR TREATMENT OF
CHILDREN

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

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 canals, 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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PATIENT HISTORY FORM

Patient Name:_____**Age/DOB:**_____

Parents'/Guardians' Names:_____

PCP Name: _____

Address:_____

Phone: _____ **Fax** _____

Family Information:

Language(s) spoken in the home:_____

Names and ages of siblings:_____

Names and types of pets:_____

Home situation (parents married/divorced?): _____

Child lives with: _____

List Current Concerns/Problem Areas:_____

_____

_____

Patient/Care-Giver Goals (In your own words, what would you like to achieve in therapy):

_____

_____

Medical History

List any significant Medical History *(chronic ear infections/ tubes/ reflux/ surgeries, illness, hospitalization, etc...):*

___Chronic ear infections	___Seizures
___Tubes	___Vision deficits
___Tonsils/Adenoid Surgery	___Hearing problems
___Reflux	___Torticollis
___Surgeries: list above	___Frequent antibiotic use
___Poor sleep	___Frequent fevers
___Colic	___Compromised immune system
___Asthma	___Abnormal Lab results
___Allergies	___Cardiac Issues
___Abnormal muscle tone	___Lyme Disease
___Hearing defect	___Poor weight gain
___Physical injuries	___Other:
___Meningitis	___Other:

Additional Diagnosis: Please indicate any medical diagnosis or medical condition below:

_____

_____

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Patient Name_____ DOB _____

Hospitalizations, Surgeries, & Diagnostic Testing (please list)

_____

_____

_____

Allergies/Reactions (food, latex, medication, other - please list):

_____

_____

Medication: Please include prescription drugs, over the counter medication, vitamins, and homeopathic medications.

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Precautions/Contraindications: _____

_____

_____

Equipment/Orthotics: _____

Birth History:

___Full Term ___Premature _____ wks Birth Weight: _____

___Vaginal Delivery ___Caesarean Delivery

How long was your child in the hospital following his/her birth? _____

Please describe any complications with the pregnancy or delivery: _____

_____

_____

Developmental History: Please list in months when the following first occurred:

Held up head: _____ Craw:l _____
Rolling tummy to back: _____ Rolling back to tummy: _____
Sitting without support: _____ Walking: _____
Smile: _____ First words: _____
Finger foods: _____ Use a spoon: _____
Dress self: _____ Potty trained:_____

Hand Dominance: ___Right ___Left ___Not Sure

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Patient Name _____ DOB _____

Other Therapeutic Services:

Occupational Therapist: _____ School/Clinic:_____
Physical Therapist: _____ School/Clinic:_____
Speech Therapist: _____ School/Clinic:_____

Other Services:
Please list any other professionals and agencies who are currently seeing or have seen your child:

	Name	Phone #
Case Worker:		
Early Intervention:		
Neurologist:		
Gastroenterologist:		
Ear Nose and Throat (ENT):		
Other Specialist -Physician:		
Mental Health/Behaviorist:		
Audiologist:		
Nutritionist/Dietician:		
Public Health Nurse:		
Other:*		

Please list any other information you would like your therapist(s) to know: _____

_____

Academic/ Educational History

___School/Pre-School: _____ Grade: _____
___Is not enrolled in school/pre-school

My child... (*Fill in the blanks and check appropriate boxes that describe your child)*

___Does well in school: _____
___Does well with the exception of: _____
___Is challenged by school: _____
___Is challenged by writing: _____
___Is challenged by reading: _____
___Receives resource/ tutoring for: _____
___Receives classroom support for: _____
___Is an A B C D F Student
___Is in a self-contained classroom

List any academic/school concerns: _____

_____

List specific teacher concerns: _____

_____

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Patient Name _____ DOB _____

Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:
_____
_____

Please complete the following to allow your child to participate in snack activities:

_____ My child may participate in snacks and has no diet restrictions.

_____ My child may participate in snacks if diet restrictions are observed.
Diet Restrictions: _____
_____

_____ My child may participate in snacks; however, I will provide his/her snack.

_____ My child should **not** participate in snack time. Please list the food(s) your child is motivated to eat: _____
_____

_____ _____ _____
Parent/Guardian Signature Relationship Date

Therapist/Witness _____Date: _____

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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:_____
_____

Child's Name: _____Birthdate:_____

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.)? _____