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:

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

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

7/30/18 ksw

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.

<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** □ **Multi-racial**

<u>Ethnicity</u>- relates to nationality and culture:
□ **Latino/Hispanic** □ **Non Latino**

Do you live in public housing:
□ **Yes** □ **No**

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

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