CHATTERBOXNYC SLP

WHERE EVERY WORD IS PRECIOUS

Tricia Brown | Jackie Dolson-Shewchuk | Julie Silberman | Sarah Shiovitz

Patient Intake Form

Please provide the information requested below as completely as you can.
All information is confidential and will not be released without your permission.

Date: _____

Patient Name:	Age:	Date of Birth:	☐ Male ☐ Female
Parent(s) Name(s):	Address:		
Home Phone:	Cell Phone:	Work Phone:	
Email Address(es):			
Caregiver Name & Phone Number, if applicable:			
Pediatrician Name & Phone Number:			
Primary & Other Languages Spoken at Home:			
Sibling(s) Names & Ages:			
What is your general availability for therapy sessions, Monday-Saturday?			
How Did You Hear About Us?			

SCHOOL/DAY CARE

School	Address & Phone Number	Teacher/Contact	School Schedule

Has your child received any diagnoses from a provider or specialist? Please list, including ICD-10 code(s) if known:

MEDICAL SERVICES

Discipline	Name & Number	Date of Visit	Diagnosis/Recommendation
Developmental Pediatrician			
Neurologist			
Psychologist			
ENT/Audiologist			
Ophthalmologist			
Nutritionist			
Other			

THERAPEUTIC SERVICES

Discipline	Therapist	Therapist Contact Info	Frequency/Duration
Speech Therapy			
Occupational Therapy			
Physical Therapy			
ABA Therapy			
SEIT			
Other			

BACKGROUND INFORMATION

Was your baby born within two weeks before or after due date? ☐ Yes ☐ No

Were there any complications reported by physicians, etc., during pregnancy, at birth or shortly after birth?
☐ Yes ☐ No | If 'Yes' please explain:

Baby's birth weight _____
Did your baby come home from the hospital with the mother?

☐ Yes ☐ No | If 'No' please explain:

Please list any illnesses, accidents, or surgeries?

Does your child have any allergies? Please list.

Has this child had their hearing assessed? ☐ Yes ☐ No

Date of last testing:	Location:	Results:

DEVELOPMENTAL MILESTONES

Milestone	Age	Comments
Walk		
Feed Self		
Give Up Bottle/Breast		
Give Up Pacifier/Thumb		
Follow Simple Directions		
Babble		
First Words		
Combine Words		

At this time, what concerns you most about your child? (Check all that apply):

- ☐ Speech & language
- ☐ Feeding skills
- ☐ Motor skills development (i.e., walking, running, climbing, etc.)
- ☐ Child's ability to interact or play with others
- ☐ Child's behaviour with parents, siblings, others
- ☐ Child's overall/academic or development/progress
- ☐ Other (please explain):

How does your child currently communicate their needs (signs, gestures, vocalizations, words, sentences)?

Does your child appear frustrated or upset about their lack of ability to speak or communicate?
☐Yes ☐No

If yes, how does your child indicate this frustration?

- ☐ Becomes quiet or withdraws
- ☐ Appears angry/upset, cries when not understood
- ☐ Throws temper tantrums or refuses to comply
- ☐ Other (please explain):

Does anyone in your child's family have a history of:

☐ speech problems ☐ language problems ☐ hearing difficulties ☐ learning disabilities

If 'Yes' please explain:

Additional Comments/Goals:

PLEASE PROVIDE COPIES OF ALL PERTINENT REPORTS
WITHIN 2 WEEKS OF INITIAL CONSULTATION

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Treatment Release Form

_____
Patient Full Name (please print)

_____
Parent/Legal Guardian Full Name (please print)

• I have read and understood the policies of ChatterboxNYC SLP. _____
Initial

• I understand my credit card will be charged for any invoices unpaid after 30 days. _____
Initial

• I understand I am responsible for all fees associated with credit card payments. _____
Initial

I GIVE ☐ **DO NOT GIVE** ☐ my consent for my child to be video recorded for the following purpose:

Video recording will be used **only for the purpose of treatment planning, evaluation, and to provide feedback and PROMPT treatment suggestions to my child's clinician.** The video will be viewed by the speech language pathologists in this office.

I GIVE ☐ **DO NOT GIVE** ☐ my consent for my child to be video recorded for the following purpose:

Video recording will be used for mentoring or training of other speech language pathologists. The video will be viewed by speech language pathologists in mentoring or teaching situations.

Signed: _____ **Date:** _____
Parent/Legal Guardian

☐ *Please check this box if you are signing this form electronically.*

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Credit Card Authorization Form

You are required to fill out and sign a credit card authorization form to be kept on file with our office. Any invoices unpaid after 30 days will be charged in full to your credit card, plus fees. Overdue invoices are also subject to a $100.00 late fee.

Complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder Zip Code (from credit card billing address):

I, _____, authorize **Talk the Talk SLP PLLC (dba ChatterboxNYC)** to charge my credit card above for agreed upon services rendered. I understand that my credit card will only be charged for invoices unpaid after 30 days and all credit card transactions will include additional fees of 2.9% of total amount due + $0.25 per transaction.

Signed: _____ **Date:** _____
Cardholder Signature

☐ *Please check this box if you are signing this form electronically.*

ChatterboxNYC
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