**Karla F. Davis, M.A., CCC-SLP**
**Jan Marsden-Johnson Ph.D. CCC-SLP and Assoc.**
85 Revere Drive, Suite G
Northbrook, Illinois 60062
Ph. 847.498.2003 Fax 847.498.2018

**Intake Information:**
The information requested on this form will be used only for purposes of assessing and/or treating your child. Please disregard sections that are not applicable. A copy of your Insurance Card is required with intake form.

Child's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: (_____) _____
Parent(s)/Guardian(s) Names: _____
Mother's cell phone: _____ Mother's Email:_____
Father's cell phone:_____ Father's Email:_____
Responsible party Name:_____ Social Security #_____
Signature of Responsible Party:_____

Insurance Carrier Name_____ Policy # _____ Group #_____
Name of insured policy holder : _____ Date of Birth of policy holder:_____

Siblings' Names & Ages:
_____ _____ _____ _____
_____ _____ _____ _____

Pediatrician and/or Family Physician: _____ Other Physician(s):_____
School/Parent-Infant Program: _____
Referred By: _____
Please describe your concern(s) about your child and what you hope to learn from this evaluation:
_____
_____
_____
_____

**Prenatal and Birth History:**
Were there complications or risk factors during the pregnancy? Yes____ No____
If "yes," please explain: _____
Length of pregnancy: _____ Duration of Labor (hours): _____
Type of delivery: Vaginal_____ Cesarean_____ induced_____ interrupted_____

Please describe special circumstances: _____

_____

| | M.D./Therapist | Date(s) | Results/Recommendation |
|---|---|---|---|
| **Neurology** | | | |
| **Hearing** | | | |
| **Vision** | | | |
| **ENT** | | | |
| **Orthopedic** | | | |
| **Speech/Language** | | | |
| **Occupational Therapy** | | | |
| **Physical Therapy** | | | |
| **Other (cognitive/psychology)** | | | |

Birth weight: _____lbs. _____ oz. APGAR scores (if known): _____

Child's condition at birth: _____

Good Color? _____ Breathing easily?_____

Any sucking or swallowing difficulty? Yes: _____ Please describe: _____

How soon after birth did you see your infant? _____

Please describe any medical attention (mother or child) required: _____

If your child was in the NICU, length of stay there (days):_____

**Other Evaluations:**

Please indicate below any evaluations and/or treatment received by your child.

**Developmental History:**

Please feel free to describe your child/child's interests, activities, and/or sports: _____

_____

_____

_____

Describe your child's personality: _____

_____

At what age could your child do the following:

Hold up head alone: _____ Sit alone: _____ Crawl/creep: _____ Walk unaided: _____

Did you child ever have any motor coordination difficulties such as confusion in regard to left or right-handedness, frequent falling, awkwardness? If yes, explain:

_____

_____

Demonstrate toilet training (bowel? Bladder?): _____

**Feeding:**

How long does it take your child to eat one meal? _____

Does your child have any particular food preferences? _____

Describe any eating habits or food texture issues: _____

**Sleeping**

How many hours does your child sleep per night? ___

Does your child typically wake up at night? Yes___ No___ If yes, how many times? _____

Does your child take daytime nap(s)? Yes__ No__ If "yes:" How many_____ Length_____ Current nap times: _____

Please describe any sleeping issues: _____

_____

**Speech and Language**

During the first year, other than crying, would you describe your child as:

_____ a silent baby _____ a very quiet baby _____ a vocal baby _____ an irritable baby

Please describe your child's early vocalizations (what kinds of sounds? Babbling?) _____

_____

When did your child first speak an understandable word? _____ Put two words together? _____

What type of communication does your child understand (commands, words, simple conversation, pointing)? _____

_____

_____

How does your child typically express wants and needs? _____

_____

Has your child's communication stopped/decreased or otherwise changed significantly at any time? Yes__ No __Please describe:

_____

How easily can you understand your child's speech? _____

_____

Describe your child's play skills. Do you find those play skills to be age appropriate? _____

_____

Has your child been referred or enrolled in speech/language therapy? If yes, please indicate goals: _____

_____

**Health and Medical History**

Describe your child's general health: _____

_____

_____ Present weight: _____ lbs. Height _____ft. ____ins.

Describe Illnesses:

| | **Age(s)** | **Severity/Frequency** | **Medications/Treatment** |
|---|---|---|---|
| **Ear Infections** | | | |
| **High Fevers** | | | |
| **Head Injury** | | | |
| **Seizures** | | | |
| **Hospitalizations** | | | |
| **Asthma** | | | |

| | | | |
|---|---|---|---|
| **Other** | | | |

Does your child have any known allergies? _____ Is your child a "mouth breather"? _____
Immunizations, Age & Reactions: _____
Does your child have any medical diagnoses? _____
Child's immediate family, mother/father's families—please describe all histories of neurological, hearing, speech/language, or hereditary diagnoses: _____

**Educational History**

Child currently attends the following early intervention/parent-infant programs: _____
Child has attended the following early intervention/parent-infant programs: _____
Name, Grade, and Address of current preschool, grammar school and/or any other programs attended (including tutoring):
_____
Has your child been held back? If yes, which grade: _____
Has school reported current problems with (describe those that apply):

| | |
|---|---|
| **Reading** | Describe: |
| **Spelling** | Describe: |
| **Writing** | Describe: |
| **Math** | Describe: |
| **Social Adjustment** | Describe: |
| **Attention Span** | Describe: |
| **Following Directions** | Describe: |

What is your child's current attitude toward school? _____
Are you currently working with any other professionals regarding your child? _____
_____

Signature: _____ Date: _____
Relationship to child: _____

**Financial Responsibility and Payment Policies**

I assume full and primary responsibility and liability for payment of professional fees due to my therapist(s) at Jan Marsden-Johnson and Assoc. Karla F. Davis and Capable Kids of the North Shore, LLC. I am solely responsible for claims upon or reimbursement from my health insurance carrier. Failure of my insurance carrier to reimburse for services performed by Capable Kids therapist(s) shall in no way effect my liability for payment. You are responsible for services rendered. Our services are rendered "for" and charged to "you". If Capable Kids therapist(s) submits insurance claims on my behalf, I agree to provide a valid VISA, MasterCard, or Discover card number and expiration date for Capable Kids therapist(s) to use if I owe a co-pay, deductible, or balance. I also agree that my credit card may be charged for late charges and any services that remain unpaid 30 days after being invoiced. Capable Kids therapist will provide me with a receipt and explanation if this credit card is used. Capable Kids reserves the right to withhold release of the written report until all fees are paid.

Payment for all charges is due within 30 days after a statement date. I further understand that there will be a $25.00 fee for any returned check. Failure to make payments in a timely manner will result in a monthly finance charge of $25.00. Collection fees will be charged to your account in the event of nonpayment.

Circle type of credit card: VISA MasterCard Discover

Name on Credit Card: _____

Billing Address:_____

Credit Card Number:_____

Expiration Date:_____ Security Code (on reverse of card):_____

Cardholder Signature_____

**Assignment of Benefits**

I authorize Capable Kids therapist(s) and assign them all of my rights and claims for reimbursement of expenses allowable under any and all health insurance plans under which there is entitlement to reimbursement. I understand that I am financially responsible for charges remaining after payment (if any) under this assignment. I agree to pay all costs of collection on any outstanding balance.

Signature of Parent/Guardian _____ Date _____

I have read and understand the rates and billing policy. I understand that any charges not covered by my insurance company are my responsibility, and that Jan Marsden-Johnson and Assoc., Karla F. Davis and Capable Kids cannot guarantee insurance coverage for any services.. I understand that Jan Marsden-Johnson and Assoc., Karla F. Davis and Capable Kids will assist with obtaining reimbursement from my insurance company when necessary by providing copies of invoices and statements. Letters of medical necessity and speaking to insurance company representative will also be provided, however, excessive time spent on insurance matters may be subject to additional charges.

Signature of Parent/Guardian _____ Date _____


**Consent for Release of information**

I give permission for designated healthcare and/or educational providers to provide Jan Marsden-Johnson and Assoc., Karla F. Davis and Capable Kids of the North Shore LLC any medical, educational, or other relevant information that may be of assistance in my child's treatment.

Child's name (print)_____

Parent/guardian signature _____date_____

I give permission for Jan Marsden-Johnson and Assoc., Karla F. Davis and Capable Kids of the North Shore LLC to provide any relevant information relating to my child's speech and language services that may be of assistance to any professional I have listed.

Child's name (print)_____

Parent/guardian signature _____date_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Capable Kids of the North Shore LLC is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all clients; inform clients of our legal obligations; and advice clients of additional rights concerning their medical information. We must follow the privacy practices contained in this notice from its effective date of January 1, 2007, and continue to do so until this notice is changed or replaced. We reserve the right to change our privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all information that is maintained including information created or received before the changes were made. All clients will be notified of any changes by receiving a new notice of privacy practices.

## USES AND DISCLOSURES OF MEDICAL INFORMATION

**TREATMENT:** Your information may be disclosed to a doctor or hospital that asks for it to provide treatment.

**PAYMENT:** Your medical information may be used or disclosed to pay claims for services provided by Capable Kids of the North Shore LLC

**PERSONAL REPRESENTATIVE:** Your information may be disclosed to a family member, friend, therapist, teacher, or other person to help with treatment but only if you agree we may do so.

**RESEARCH:** Your medical information may be used or disclosed for research purposes in limited situations.

**COURT OR ADMINISTRATIVE ORDER:** Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

## INDIVIDUAL RIGHTS

**AUTHORIZATIONS:** You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. Unless you give written authorization, we cannot use or disclose your medical information for any reason except those described in this notice. You have the right to look at or get copies of your information. You have the right to request restrictions on or disclosure of your information. We are not required to agree to these additional requests, but if in agreement, we will honor the agreement, except in an emergency. Any requests must be in writing

## QUESTIONS AND COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your information, or in response to a request, you made to amend or restrict the use or disclosure of your information, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Capable Kids of the North Shore LLC

85 Revere Dr. Ste G. Northbrook, IL 60062

Signature _____Date_____