The Treatment and Learning Centers
TLC
a family of services where caring comes first

2092 Gaither Road, Suite 100
Rockville, Maryland 20850
301.424.5200
Fax 301.424.8063
TTY 301.424.5203
www.ttlc.org

OUTPATIENT SERVICES – CHILD CASE HISTORY FORM

Child Information

Date

Name / Gender	Name		Gender ☐ M ☐ F
Date of Birth / Age / School	Date of Birth	Age	Grade / School
Home Address	Street		Apartment
	City	State	Zip Code
Emergency Contact	Name		Phone

Parent / Guardian Information

Parent / Guardian One	Name		Gender ☐ M ☐ F
Phone Number	Home	Work	Cell
Employment	Employer Name		Occupation
Parent / Guardian Two	Name		Gender ☐ M ☐ F
Phone Number	Home	Work	Cell
Employment	Employer Name		Occupation
E-mail Address	Parent / Guardian One		Parent / Guardian Two

Who referred you to TLC?

Name	
Relationship to Child	
Reason for Referral	
Previous services by any TLC department?	

Other Primary Caregivers

Caregiver (other than parent / guardian)		
Name	Address	Phone

Please List all People Residing in your Home

Name	Relationship	Age

Significant Family Medical History

[e.g., Speech-Language, Hearing, Sensory/Motor or Learning Disability; impaired attention; anxiety / depression; other disease or condition]

Name	Relationship	Diagnosis

Birth and Developmental History

Birth and Infancy				
Pregnancy	**YES**	**NO**	**N/A**	**Additional Information**
Was mother's health during pregnancy good to excellent?				
Were medications taken during pregnancy?				What / when:
Was baby born at term (due date) or within two weeks before / after the due date?				
What was baby's birth weight?				
Was your child adopted?				Country of Origin:
If adopted, what was child's age at adoption?				
If adopted, is there any known history that could be related to the current problem?				
Labor and Delivery				
Were labor and delivery normal?				
Was labor induced?				
Was birth by Caesarian Section?				
Was there evidence of injury or poor health at birth?				
What were baby's APGAR scores?				
Other:				
Infancy				
Were there any feeding problems?				
Did baby exhibit average activity level?				
During the first several months of life, was baby's health good?				
Other:				
Other:				

General Development

Developmental Milestones			**N/A**	**Additional Information**
When was child able to sit unassisted?	Age:			
When did crawling emerge?	Age:			
When did walking emerge?	Age:			
When did child begin to babble?	Age:			
When did child produce first words?	Age:			
When did child begin combining words?	Age:			
Gross and Fine Motor	**YES**	**NO**	**N/A**	**Additional Information**
Is there a history of problems with gross motor skills (walking, running, climbing)?				
Are there currently any problems with gross motor skills?				
Is there a history of problems with fine motor skills (e.g., picking up objects, dressing)				
Are there currently any problems with fine motor skills?				
Which hand does child use most often?				❑ Left ❑ Right ❑ Uses both hands equally
Communication	**YES**	**NO**	**N/A**	**Additional Information**
Did speech and language development seem to progress normally, and then stop or regress?				
Does child seem to understand what is said?				
Does child follow spoken directions?				❑ 1-step ❑ 2-step ❑ 3+ steps
Does child talk?				
Does child produce vocalizations that sound like the language of the home, but are unintelligible (e.g., jargon-like)?				
Which of the following does child use most often?				❑ Sounds ❑ Syllables ❑ Gestures ❑ Sounds + gestures ❑ Single words ❑ Series of single words (pauses between words) ❑ Single words + short phrases ❑ Complete / grammatically <u>incorrect</u> sentences ❑ Complete / grammatically CORRECT sentences ❑ Retells stories / experiences others understand
Does child often hesitate when speaking and/ or repeat sounds / words / phrases?				
Child's speech / pronunciation is				❑ Understood by everyone ❑ Understood by family / caregivers ❑ Poorly understood ❑ Unintelligible ❑ Absent
Child's speech rate is				❑ Too Fast ❑ Too Slow ❑ Average
Child's volume is				❑ Too Soft ❑ Too Loud ❑ Average
Child's voice quality is				❑ Hoarse ❑ Nasal ❑ Average ❑ "Stuffed" – Like during a cold
Other:				
Hearing	**YES**	**NO**	**N/A**	**Additional Information**
Does child have a history of hearing loss?				
Does child wear a hearing aid?				
Does child appear to have difficulty hearing?				
Is child consistent in response to sounds and voices?				HA Type:
Please provide information regarding child's most recent hearing test.	Date:			Results:

Medical History	YES	NO	N/A	Additional Information
Please list all diagnoses:				
Has child ever had a fever of 104° or more?				
Is child currently under treatment for any medical condition?				
Are there any problems with vision?				
Has child had vision screened or tested?				Results:
Does child wear corrective lenses for vision?				
Is development of teeth normal?				
Does child sleep well?				
Does child have a good appetite?				
Is child on a special diet?				
Medications				
Please complete this section if child takes prescription or over-the-counter medication regularly.	**Name**	**Dose**	**How Often**	**Reason Taken**
Medication:				
Medication:				
Medication:				
Medication:				
Medication:				

Diseases or Conditions		
Please provide information regarding history of diseases.	**Age**	**Describe Treatment and / or Complications**
Allergies (i.e., food, insect bites, latex, pollen, medication, etc.)		
Chicken Pox		
Chronic Colds		
Ear Infections		
Lead Poisoning		
Measles		
Mumps		
Spasms, convulsions, or seizures		
Tonsillitis		
Other:		

Injuries and / or Surgeries		
Please provide information regarding any injury, surgery, or hospitalization.	**Age**	**Describe Treatment and / or Complications**

Previous Evaluations	YES	NO	Dates of Services	Agency/Person
Educational / Psychological Testing				
Hearing / Audiology Evaluation				
Occupational Therapy Evaluation				
Physical Therapy Evaluation				
Speech Language Evaluation				

Current and/or Previous Therapy (List All)	YES	NO	Dates of Services	Agency/Person
Counseling				
Occupational Therapy				
Physical Therapy				
Speech Language Therapy				
Tutoring				

Other Information related to Medical and / or Developmental History

Other information you would like us to know about your child's medical and / or developmental history:

Social and Emotional History

Behaviors	YES	NO	N/A	Additional Information
Is child more interested in objects than people?				
Does child demonstrate self-stimulating behaviors?				❑ Rocking ❑ Arm Flapping ❑ Hand movement ❑ Other:
Does child demonstrate head-banging?				
Does child "give up" easily?				
Does child exhibit ritualistic or compulsive behaviors?				
Does child engage in behaviors that are dangerous to self or others?				
Other:				

If child exhibits or has exhibited the following behaviors, please indicate age of occurrence and describe strategies used to address the behaviors.

Behavior	Age (from – to)	Strategies Used to Address Behavior
Bedwetting		
Depression		
Difficulty separating from parents		
Difficulty sitting still		
Frequent headaches / stomach aches		
Inability to stay with one activity until completion		
Negative self-esteem		
Nervousness / anxiety		
Noncompliant / defiant		

Behavior	Age (from – to)	Strategies Used to Address Behavior
Physically strikes out at others		
Shyness		
Sleeplessness		
Strong fears – nightmares		
Temper tantrums		
Thumb sucking		

Please answer the following questions regarding your child's behavior.			
What types of activities or toys does your child prefer?	Please describe:		
Does your child play with other same-age peers?	**YES**	**NO**	Please describe:
Are you ever concerned that your child doesn't play well with other children?	**YES**	**NO**	Please describe:
Do you feel that your approach to discipline is effective?	**YES**	**NO**	Please describe:
Other Information related to Social and Emotional History			
Other information you would like us to know about your child's social and emotional history:			

Language History

Child's Primary Language	
Other Language Exposure	
Age at which other Language(s) Introduced	
Where (e.g., Home, Daycare, or School)?	
Who Speaks other Language?	
Child is able to	❑ Speak _____ ❑ Understand _____ ❑ Write _____ ❑ Speak _____ ❑ Understand _____ ❑ Write _____

Educational History

Name of public school district where child lives			
Current school			
Previous school(s) (include preschool)			
Highest grade completed	1 2 3 4 5 6 7 8 9 10 11 12		Current Grade:
Has child ever repeated a grade?	**YES**	**NO**	**Please describe, including grade(s) repeated**
Are there any current concerns regarding school performance?	**YES**	**NO**	**Please describe**
Does child receive any special services at school?	**YES**	**NO**	**If so, what services are received?**

Additional information

Other information you would like us to know about your child:

Primary Care Physician		
Name	Address	Phone

Person Completing this Form	
Relationship to the Child	

Signature: _____ **Date:** _____

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Auditory Processing Questionnaire

Child=s Name:_____ Date:_____

Date of Birth:_____

Person Completing Form:_____ Relationship:_____

Please respond to these statements in relation to this child/student:

	Yes	No	Sometimes	Not Sure
AUDITORY AWARENESS				
Can find the source of sound				
Reacts to sudden loud noises				
AUDITORY SENSITIVITY				
Seems too sensitive to sounds				
Responds fearfully to sudden noises or fears specific noises				
Is distracted by sounds such as refrigerator, fluorescent light bulbs, fans, etc.				
Enjoys strange or loud noises - may enjoy making loud noises				
AUDITORY FIGURE/GROUND				
Is easily distracted by background sound(s)				
Gets Aconfused@ in noisy situations				
Avoids group activities				
AUDITORY ATTENTION				
Is inattentive or likely to daydream in class				
Has a short attention span for spoken information during tasks chosen by another person				
Does not pay attention to instruction 50% or more of the time				

	Yes	No	Sometimes	Not Sure
AUDITORY MEMORY				
Forgets what is said in a few minutes				
Often needs directions/information repeated				
Has difficulty recalling a sequence that has been heard				
Experiences difficulty following spoken directions, but does better with visual cues				
Has or had difficulty learning rote sequences such as alphabet, days of week...				
AUDITORY DISCRIMINATION				
Often misunderstands what is said				
Experiences problems with sound discrimination (i.e., confuses doorbell with phone)				
Experiences problems with speech sound discrimination (i.e., confuses words which sound similar)				
Says Ahuh?@ or Awhat?@ at least five or more times a day				
AUDITORY COHESION				
Has difficulty understanding more abstract language, idioms, (i.e., it=s raining cats and dogs) or homonyms (i.e., hear/here)				
Has difficulty understanding humor				
Displays slow or delayed response to verbal stimuli				
Frequently makes off-topic or inappropriate comments				
BEHAVIORS				
Gets teased or left out because of difficulty with peers				
Is rarely included in group conversations				
Has difficulty participating in group interactions				
Has difficulty understanding or integrating visual/body cues with verbal cues (i.e., misinterprets another person=s mood or demeanor)				
Is judged by teachers/adults as a child who Aneeds to apply him/herself@				
READING				
Reads with appropriate expression				
Reads at appropriate loudness level				
Pauses briefly at commas and other appropriate markers				

	Yes	No	Sometimes	Not Sure
Correctly identifies number of sounds in a word				
Sounds out unfamiliar words by dividing into syllables				
Produces all syllables in a word (i.e., not deleting weaker syllables)				
Appears to display few or no word attack strategies				
Seems to lose track of position on page when reading				
Acquired reading skills later than peers				
Seems to lose track of theme or train of thought of passage being read				
Fails to make adequate interpretations				
Fails to be able to summarize what was read				
Often omits words and/or lines without being aware				
WRITING				
Has spelling skills appropriate for grade level				
Has trouble formulating thoughts on paper				
Uses strategies/rules to spell words				
COGNITIVE				
Academic performance appears lower than ability				

Comments:

_____

_____

_____

_____

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FOR TEACHER PLEASE

Auditory Processing Questionnaire

Child=s Name:_____

Date:_____

Date of Birth: _____

Person Completing Form: _____ Relationship:_____

Please respond to these statements in relation to this child/student:

	Yes	No	Sometimes	Not Sure
AUDITORY AWARENESS				
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AUDITORY SENSITIVITY				
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AUDITORY ATTENTION				
Is inattentive or likely to daydream in class				
Has a short attention span for spoken information during tasks chosen by another person				
Does not pay attention to instruction 50% or more of the time				

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Often needs directions/information repeated				
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Uses strategies/rules to spell words				
COGNITIVE				
Academic performance appears lower than ability				

Comments:

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Informed Consent and Authorization for Services
Authorization to Use, Obtain, and / or Disclose Protected Health Information

Consumer Name: _____ **Birth Date:** _____

Consent for Services

I hereby authorize, consent, and direct TLC - The Treatment and Learning Centers, or its agents, officers, employees, and representatives to use procedures, methods, and materials that it deems prudent, reasonable, and appropriate to provide the requested services indicated below.

Authorization to Use, Obtain and / or Disclose Protected Health Information

I authorize my TLC professional and / or administrative staff to Use, Obtain, and / or Disclose the following protected health information.

Select the Service to be provided and / or the Protected Health Information to be used, obtained and/or disclosed

(check all that apply)

- ☐ Audiology
- ☐ Occupational/Physical Therapy
- ☐ Speech-Language Therapy
- ☐ Medical
- ☐ Tutoring/Coaching
- ☐ Educational
- ☐ Psychological
- ☐ Other: (describe) _____

Type of Information (check all that apply)

I further authorize TLC to use, obtain and / or disclose Protected Health Information in the following form(s):

☐ Written	☐ Verbal Exchange	☐ Video / Audio Records	☐ Text Message	☐ Other:
☐ Fax		☐ Voice Mail	Email Yes ☐ No ☐ (see page 2 if you checked Yes)	
			Email:	

I authorize TLC to exchange information with the following:

NAME	FULL ADDRESS [Include PHONE, if applicable]
Self/Parent [*you must be listed if you want a copy of reports*]:	
Physician:	
School or Funding Agency:	
Other:	

TURN OVER, PLEASE →

This protected health information is being used or disclosed at your request for follow-up by participating professionals, and / or for insurance / reimbursement purposes, and research. (If used for research, no identifying information will be released.)

I hereby release TLC, its agents, officers, employees, and representatives from legal responsibility or liability for services provided or information released pursuant to this Authorization.

NOTE REGARDING INSURANCE: TLC is **not** a participating provider with any HMO, PPO, or POS, or any other INSURANCE plan except for the following:

(1) CIGNA **(occupational therapy, physical therapy, speech therapy, and audiology)**
(2) United Healthcare **(audiology only)**
(3) Medicare **(audiology only)**.

I authorize TLC to submit claims for plan-eligible services to my insurance carrier; TLC will submit claims to the listed plans only. I understand that I will be required to pay copayments, amounts applied to deductibles, and any charges not paid in accordance with the benefits of the insurance plan in effect at the time services are rendered. In the event of nonpayment of submitted claims, I agree to pay the full billed charges for all services rendered.

I understand that I have the right to revoke this authorization at any time by sending written notification to

Director of Administrative Services, TLC
2092 Gaither Road, Suite 100
Rockville, MD 20850

Unless revoked in writing, this authorization shall be in force and effect for 1 year from the date of this document, at which time this authorization to use and / or disclose this protected health information will expire.

ACKNOWLEDGEMENTS

EMAIL CONSENT NOTICE (If you checked Yes to email on page 1)

Your signature below is your request to communicate personally identifiable information concerning your / your child's services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the Client or other responsible party.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Acknowledgement and Agreement

I acknowledge that I have read and understand the items above that describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I authorize TLC – The Treatment and Learning Centers and members of my treatment team to communicate with me at my e-mail address concerning services provided to me / my child, including but not limited to, communication regarding service delivery, my / his / her progress towards goals, and any other related matters. I

understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

I further agree that I will not use e-mail to communicate with TLC, and will use other means of communication (e.g., telephone, in-person visit, etc.) for the following:

- Emergencies or other time-sensitive issues that require immediate action
- Inquiries that deal with sensitive information
- Situations in which TLC does not / is unable to respond to an e-mail communication (e.g., offices closed, power outage)

I understand that TLC will make a reasonable attempt to return all e-mail messages received within two (2) business days; however, if I do not receive a response by the close of business on the second business day following my e-mail communication, I agree to use other means of communication to contact TLC. I further understand that e-mail communications with TLC is offered as a convenience to me, and agree to not hold TLC responsible for any expense, loss, or damage caused by or resulting from the following:

- A delay in TLC's response, or any damage to me / the Client resulting from such delay, including, but not limited to the following: therapist absence, therapist inability to respond, technical failures attributable to TLC's internet service provider, power outages, failure of TLC's electronic messaging software, failure by TLC or me / the Client to properly address e-mail messages, failure of TLC's computers / computer network, or faulty telephone / cable data transmission
- Any interception of my or TLC's e-mail communications by a third party
- My failure to comply with the guidelines regarding use of e-mail communications set forth above

HIPAA PRIVACY NOTICE

By signing this form, you acknowledge that The Treatment & Learning Centers / KTS has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this acknowledgement on your first date of service with us.

The Practice has provided me access to its Privacy Notice. I understand I may request a copy of this Privacy Policy for my personal use.

GENERAL ACKNOWLEDGEMENT

I acknowledge that I have read, understand, and agree to the contents of this document.
I understand and agree to the policies, procedures and fees related to the services that I have requested.

_____ _____

Signature of Person Receiving Services or Legal Representative Date

_____

Relationship to Person Receiving Services

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Date: _____

Dear Consumer,

Because we are a nonprofit that accepts government funding and foundation grants for some of our services, we are asked to keep certain demographic statistics about the clients we serve.

Your answers to the question below are totally voluntary and confidential. This form will not be a part of, nor ever identified with, the consumer's file.

Thank you for your assistance.

Consumer Ethnic Background:

Native American: _____

Black/African American: _____

Asian: _____

Hispanic/Latino: _____

White: _____

Other Ethnicity: _____

Pacific Islander: _____

Two or more races: _____

Reviewed/Revised: 11/14
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