



**OUTPATIENT SERVICES – CHILD CASE HISTORY FORM**

**Child Information**

**Date**

Name / Gender	Name		Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F
Phone Number	Home	Work	Cell
Employment	Employer Name		Occupation
Parent / Guardian Two	Name		Gender <input type="checkbox"/> M <input type="checkbox"/> 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

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**Please List all People Residing in your Home**

Name	Relationship	Age

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

**Significant Family Medical History**

Name	Relationship	Diagnosis

**Birth and Developmental History**

<b>Birth and Infancy</b>				
<b>Pregnancy</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
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?				
<b>Labor and Delivery</b>				
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:				
<b>Infancy</b>				
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:				

<b>General Development</b>					
<b>Developmental Milestones</b>		<b>N/A</b>		<b>Additional Information</b>	
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:				
<b>Gross and Fine Motor</b>		<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
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?				<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Uses both hands equally	
<b>Communication</b>		<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
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?					<input type="checkbox"/> 1-step <input type="checkbox"/> 2-step <input type="checkbox"/> 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?				<input type="checkbox"/> Sounds <input type="checkbox"/> Syllables <input type="checkbox"/> Gestures <input type="checkbox"/> Sounds + gestures <input type="checkbox"/> Single words <input type="checkbox"/> Series of single words (pauses between words) <input type="checkbox"/> Single words + short phrases <input type="checkbox"/> Complete / grammatically <u>incorrect</u> sentences <input type="checkbox"/> Complete / grammatically <b>CORRECT</b> sentences <input type="checkbox"/> Retells stories / experiences others understand	
Does child often hesitate when speaking and/ or repeat sounds / words / phrases?					
Child's speech / pronunciation is					<input type="checkbox"/> Understood by everyone <input type="checkbox"/> Understood by family / caregivers <input type="checkbox"/> Poorly understood <input type="checkbox"/> Unintelligible <input type="checkbox"/> Absent
Child's speech rate is				<input type="checkbox"/> Too Fast <input type="checkbox"/> Too Slow <input type="checkbox"/> Average	
Child's volume is				<input type="checkbox"/> Too Soft <input type="checkbox"/> Too Loud <input type="checkbox"/> Average	
Child's voice quality is				<input type="checkbox"/> Hoarse <input type="checkbox"/> Nasal <input type="checkbox"/> Average <input type="checkbox"/> "Stuffed" – Like during a cold	
Other:					
<b>Hearing</b>		<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
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:

<b>Medical History</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
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?				
<b>Medications</b>				
<b>Please complete this section if child takes prescription or over-the-counter medication regularly.</b>	<b>Name</b>	<b>Dose</b>	<b>How Often</b>	<b>Reason Taken</b>
Medication:				
Medication:				
Medication:				
Medication:				
Medication:				
<b>Diseases or Conditions</b>				
<b>Please provide information regarding history of diseases.</b>	<b>Age</b>	<b>Describe Treatment and / or Complications</b>		
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:				
<b>Injuries and / or Surgeries</b>				
<b>Please provide information regarding any injury, surgery, or hospitalization.</b>	<b>Age</b>	<b>Describe Treatment and / or Complications</b>		
<b>Previous Evaluations</b>	<b>YES</b>	<b>NO</b>	<b>Dates of Services</b>	<b>Agency/Person</b>
Educational / Psychological Testing				
Hearing / Audiology Evaluation				
Occupational Therapy Evaluation				
Physical Therapy Evaluation				
Speech Language Evaluation				

<b>Current and/or Previous Therapy (List All)</b>	<b>YES</b>	<b>NO</b>	<b>Dates of Services</b>	<b>Agency/Person</b>
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**

<b>Behaviors</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Additional Information</b>
Is child more interested in objects than people?				
Does child demonstrate self-stimulating behaviors?				<input type="checkbox"/> Rocking <input type="checkbox"/> Arm Flapping <input type="checkbox"/> Hand movement <input type="checkbox"/> 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.*

<b>Behavior</b>	<b>Age (from - to)</b>	<b>Strategies Used to Address Behavior</b>
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?	<b>YES</b>	<b>NO</b>	Please describe:
Are you ever concerned that your child doesn't play well with other children?	<b>YES</b>	<b>NO</b>	Please describe:
Do you feel that your approach to discipline is effective?	<b>YES</b>	<b>NO</b>	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	<input type="checkbox"/> Speak _____ <input type="checkbox"/> Understand _____ <input type="checkbox"/> Write _____ <input type="checkbox"/> Speak _____ <input type="checkbox"/> Understand _____ <input type="checkbox"/> 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?	<b>YES</b>	<b>NO</b>	<b>Please describe, including grade(s) repeated</b>										
Are there any current concerns regarding school performance?	<b>YES</b>	<b>NO</b>	<b>Please describe</b>										
Does child receive any special services at school?	<b>YES</b>	<b>NO</b>	<b>If so, what services are received?</b>										

### Additional information

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

#### Primary Care Physician

Name	Address	Phone
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Person Completing this Form	
Relationship to the Child	

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## INFORMED CONSENT AND OFFICE POLICIES AND PROCEDURES FOR PSYCHOTHERAPY/COUNSELING

Welcome! We want to make your visits for therapy a helpful experience for you. We believe open communication and clear agreements will facilitate this. This memo contains the key administrative guidelines we follow regarding therapy. Please take time to read this and, if you have questions or concerns, please discuss them with us.

### **Methods of Therapy - Informed Consent/Limitations on Treatment Options**

The therapy methods that will be used are generally accepted professional practices. The specific approach and techniques used with you will be chosen to best meet your particular needs and situation; feel free to ask any questions you have about treatment methods, alternative techniques that would be available, and the risks and benefits of therapy approaches. Psychotherapy can bring up intense emotions, and it is not unusual for clients to feel worse before they feel better: it is important to discuss any negative reactions or concerns you have with your therapist.

If you are submitting claims to a managed care health plan, please be advised that managed care plans typically cover only brief therapy for acute conditions and severe symptoms, and may not cover therapy techniques that deal with less severe symptoms or that are intended for problems that require longer-term treatment. While brief therapy for acute symptoms is often the most appropriate treatment, if longer-term therapy is indicated, we will discuss with you your clinical situations and the options available.

### **Confidentiality/Release of Information**

Maryland law recognizes that the counselor-client communication is privileged and, as such, any information concerning your treatment can only be released with your written consent. We take your privacy seriously and will not violate legal or professional standards of confidentiality.

There are some exceptional circumstances in which we are legally required to disregard the treatment confidentiality and to contact authorities or to testify in court without the client's consent. Specifically, in cases regarding child abuse or child neglect, we may be legally required to contact the Child Protection Authorities or to testify in court. In cases where an elderly or disabled adult may be being abused or neglected, we are legally required to contact the Adult Protective Services. We may also be required to violate confidentiality if we believe that notifying authorities will prevent someone from committing a serious violent crime.

If you are using health insurance to pay for part of the cost of therapy, your signature on the insurance claim form gives the insurance company the right to information about your treatment. When you submit a claim to the insurance company, we will have to provide diagnostic information to the insurance company, and the insurance company will have the right to access your full treatment record if they wish. If your insurance is a managed care plan, which requires

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their pre-authorization for coverage of therapy, they may also require that we sent them periodic reports on your condition, symptoms, and progress in treatment.

There may be occasions where-at your request or at our suggestion-you will give us permission to discuss your treatment with another professional involved in your care.

Please feel free to raise any questions or concerns you have about the privacy of your treatment.

### **Payments**

Unless otherwise agreed upon, fees are due and payable at the time of the session. You will be given a fee agreement at your first visit with the exact charge for services.

Returned checks will be subject to an administrative fee. Accounts behind in payment by more than 60 days may be referred to a collection agency; if we do have to use an attorney to collect fees due TLC, you agree to pay the attorney and court costs.

Written reports and extended telephone consultations or email exchanges will be subject to separate charges, which will not be covered by insurance. Photocopies of your records are available to you, subject to fees authorized by state law.

### **Missed Appointments and Cancellations**

Since a specific time is reserved for you, there will be a 50% charge for all missed appointments not canceled at least 12 hours in advance.

If you miss an appointment without giving any prior notice at all, you will be charged the full fee for the session. Exceptions which may be made for emergencies are at TLC's discretion.

### **Statement of Understanding Regarding Office Policies and Procedures**

I have read Informed Consent and Office Policies and Procedures of TLC-The Treatment and Learning Centers. I understand them and agree that they will be in effect during my treatment with TLC.

Signature of Parent, Client,  
or Authorized Adult \_\_\_\_\_ Date \_\_\_\_\_

Name of Client (please print): \_\_\_\_\_

Effective: 1/07

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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)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Audiology                     | <input type="checkbox"/> Medical           | <input type="checkbox"/> Psychological           |
| <input type="checkbox"/> Occupational/Physical Therapy | <input type="checkbox"/> Tutoring/Coaching | <input type="checkbox"/> Other: (describe) _____ |
| <input type="checkbox"/> Speech-Language Therapy       | <input type="checkbox"/> Educational       |  |

**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):

<input type="checkbox"/> Written	<input type="checkbox"/> Verbal Exchange	<input type="checkbox"/> Video / Audio Records	<input type="checkbox"/> Text Message	<input type="checkbox"/> Other:
<input type="checkbox"/> Fax	<input type="checkbox"/> Voice Mail	Email Yes <input type="checkbox"/> No <input type="checkbox"/> (see page 2 if you checked Yes)		
		Email: _____		

I authorize TLC to exchange information with the following:

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

**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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Patient's Name: \_\_\_\_\_

Dear Doctor:

One of your patients has been referred to TLC —The Treatment and Learning Centers for Testing or Counseling Services. We would appreciate any information you could provide about this patient so that we may have an accurate medical history to consider in our evaluation.

Thank you for your time.

Sincerely,  
The Clinical Team at TLC

Return to:

The Treatment and Learning Centers  
2092 Gaither Road, Suite 100  
Rockville, MD 20850  
Attn: Testing & Tutoring Services

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**TESTING DIAGNOSTIC AND SUPPORT SERVICES  
PHYSICIAN'S REFERRAL FORM**

Client Name \_\_\_\_\_ Client Birthdate \_\_\_\_\_

Client Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Reason for Referral:**

**Pertinent Medical History:**

**Current Health Status (please include medication dosage and frequency):**

**Previous Testing:**

**Date of Recommended Return Visit:**



**Additional Comments:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (please print) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

10/09

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Fax 301.424.8063  
TTY 301.424.5203  
www.ttlc.org

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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