GENERAL CONSENT

I. GENERAL CONSENTS AND ACKNOWLEDGEMENTS

A. CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I give permission for NUCASLL to provide medical services such as diagnosis, treatment, and clinical procedure that may be deemed necessary on my behalf. I acknowledge that no guarantees have been made to me about the results of my examination or treatment by any NUCASLL clinician.

B. ACKNOWLEDGEMENT OF EDUCATIONAL AND RESEARCH MISSIONS

NUCASLL is dedicated to promoting quality services to the community. This mission is accomplished by providing clinical care, training future professionals, and participating in clinical and translational research. I understand that my care will be provided in a teaching environment and that professionals in training will be involved in my care and treatment.

C. RECORDING

I am aware that audio and video recordings are used routinely during diagnostic (testing and interviewing) and treatment sessions and that there may be observers present during these sessions at Northwestern University. I, on behalf of myself and/or my minor child authorize audio and video recordings for clinical diagnostic, treatment and educational purposes within and external to Northwestern University including local and national conferences by Northwestern University faculty and I will make no monetary or other claims against the University for their use. I understand that this permission extends to any and all sessions that I (or my minor child, if applicable) have at the Center for Audiology, Speech, Language and Learning.

II. HEALTH INFORMATION

I understand that NUCASLL records medical and other information related to my diagnosis, care, and treatment in electronic, video, audio, and other forms. I certify that any information regarding my history or medical condition communicated to NUCASLL is true and complete to the best of my knowledge. I understand that my medical information is confidential and will only be used by NUCASLL staff for proposes related to my medical care and will only be released to others with my consent. I give permission for NUCASLL to exchange medical information with my insurance company and/or their designated agents, the insurance policy holder, and/or other providers of healthcare services for purposes of insurance certification for tests or procedures recommended by NUCASLL providers. I also give permission to NUCASLL to provide medical information necessary to provide continuity of care recommended by NUCASLL staff to non-NUCASLL providers of healthcare or related diagnostic or therapeutic services.

III. FINANCIAL RESPONSIBILITY

I agree that I am financially responsible to and agree to pay NUCASLL for all services provided to me. NUCASLL bills current rates based on NUCASLL Chargemaster, which is a list of charges for services and supplies and discounted rates that may apply to those services or supplies.
If I choose to have my health insurance cover my treatment, I authorize NUCASLL to bill any such insurer for all medical services and products provided. My insurance company may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, or charge not covered by my health insurance. NUCASLL will bill me for the amount that is my responsibility. I understand my insurer may deny payment for services that the insurer decides are not “medically necessary” or that are “experimental”. While NUCASLL will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer, including those deemed medically unnecessary or experimental.

If I choose to have my health insurance pay for my treatment, I give up my rights to receive payment from my health insurance and assign the rights to receive payment to NUCASLL. I agree to cooperate and provide information as needed by NUCASLL to establish my eligibility for my insurance benefits.

IV. RECEIPT OF WRITTEN MATERIALS

I acknowledge receipt of NUCASLL’s Notice of Privacy Practices.

V. RESEARCH

NUCASLL is housed within Northwestern University’s Roxelyn and Richard Pepper Department of Communication Sciences and Disorders (CSD), which houses a strong research arm and helps support our mission of delivery of high quality clinical care. As a patient at NUCASLL, you are granted the opportunity to participate in a variety of research studies. Unless I check the “I do not agree” circles below:

I give permission for NUCASLL to share my contact information with NU CSD researchers so that I may be contacted about participating in research projects.  ○ I do not agree

I give permission for NU researchers to access my past and future clinical information housed in NUCASLL medical record systems for research purposes. The information will always be used in an anonymous manner.  ○ I do not agree

VI. MARKETING AND EDUCATION

Unless I check the “I do not agree” circle below, I agree that to receive newsletters, fundraising information, and news about upcoming events, specials and articles pertaining to services or products in the clinic.  ○ I do not agree

VII. SIGNATURE

My written or electronic signature indicates my agreement with and acknowledgment of the above.

Signature of Patient, Parent if patient is under 18, or Legally Authorized Representative

Date of Signature

Relationship of Legally Authorized Representative to Patient
PATIENT
First________________________________ Last ______________________________
Address _______________________________________________________________
City, State, Zip________________________________________________________________
Home Phone ___________________________ Cell Phone ___________________________
Date of Birth _____________________________ Sex Male/Female
Language________________________________ Interpreter Needed Yes/No
Race _________________________________ Ethnicity________________________
Insurance _____________________________ Authorization Needed Yes/No
Group # ___________________________ ID or Recipient # ___________________________

MOTHER
First________________________________ Last ______________________________
Cell Phone ___________________________ Work Phone _______________________

FATHER
First________________________________ Last ______________________________
Cell Phone ___________________________ Work Phone _______________________

EMERGENCY CONTACT
First________________________________ Last ______________________________
Cell Phone ___________________________ Alternate Phone _______________________
Relationship to Patient ___________________________________________________

PRIMARY CARE PHYSICIAN/PEDIATRICIAN
First________________________________ Last ______________________________
Address _______________________________________________________________
City, State, Zip__________________________________________________________
Office # ___________________________ Fax # ___________________________
CENTER FOR AUDIOLOGY, SPEECH, LANGUAGE AND LEARNING (NUCASLL)
NOTICE OF PRIVACY PRACTICES

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

NU STUDENTS
If you are a student of Northwestern University, we will maintain your medical information in accordance with the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232 g (“FERPA”). FERPA contains a right of access, subject to certain limitations, and restrictions on disclosure. Please refer to your Student Handbook and in the Office of the Registrar’s website, http://www.registrar.northwestern.edu/ferpa/, for detailed information about Northwestern University’s FERPA policies. In addition to FERPA, we will also maintain your medical information in accordance with applicable Illinois law, including but not limited to: the Illinois Speech-Language Pathology and Audiology Practice Act and the rules promulgated thereunder, the Illinois Code of Civil Procedure, the Illinois Mental Health and Developmental Disabilities Code and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

PATIENTS (OTHER THAN NU STUDENTS)
Northwestern University (“NU”) Department of Communication Sciences and Disorders is one of the health care components of NU. NU is a not-for-profit teaching and research institution. The Department operates three clinics: (i) Audiology Clinic, (ii) Speech, Language and Learning Clinic and (iii) Voice, Speech and Language Service and Swallowing Center. All services provided at the clinics are overseen and supervised by Northwestern University faculty who are licensed health care professionals. Students of NU participate in clinical care as part of their education and training. This Notice applies to the information practices of the Department and its staff, faculty and students.

We are committed to protecting your medical information. We maintain records of services provided for your care and treatment. This Notice describes how we may use and disclose your medical information contained in the records. We are required by law to:

• Maintain the privacy of your medical information;
• Give you this Notice of our legal duties and privacy practices with respect to your medical information; and
• Follow the terms of this Notice or the current notice in effect.

This Notice is effective August 1st, 2014. This Notice will remain in effect until we amend or replace it. We reserve the right to amend or replace this Notice at any time, and to apply the terms of the revised notice to all medical information that we maintain. All such amendments or revised notices will be in accordance with applicable law. You may obtain a copy of the current notice on our website, www.communication.northwestern.edu by contacting our Privacy Officer or Assistant Privacy Officer. Our Privacy Officer is the chairperson of the Roxelyn and Richard Pepper Department of Communication Sciences and Disorders, currently Sumitrajit Dhar (s-dhar@northwestern.edu; 847 491 3066). Our Assistant Privacy Officer, Aaron Wilkins, NUCASLL@northwestern.edu; 84-491-3165.
The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we explain what we mean and give some examples. Not every use or disclosure is listed. However, every use of disclosure falls into one of these categories. Also, in some cases Illinois law may limit us from disclosing special types of medical information. For example, Illinois law generally requires that we get your permission before disclosing mental health, alcohol/drug use and abuse, and HIV/AIDS information.

**ABOUT THIS NOTICE**

The Northwestern University Center for Audiology and Speech Language and Learning is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1196 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or audiological and speech language and learning /health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and our duties with respect to your protected health information.

“Protected health information” is information about you that may identify you and that relates to your past, present or future physical or mental health/condition and related audiological and speech language and learning /health care services. We must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our Assistant Privacy Officer, Aaron Wilkins, at (847) 491-3165 or NUCASLL@Northwestern.edu.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following categories describe the different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

1. **Treatment**
   We may use and disclose your protected health information to provide, coordinate, or manage your audiological and speech, language and learning treatment and any related services. We may also disclose your protected health information to other third party providers involved in your audiological and speech, language and learning /health care. For example, your protected health information may be provided to a physician or other audiological and speech language and learning /health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiological and speech language and learning /health care provider has the necessary information to diagnose or treat you.

2. **Payment**
   We may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payors. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiological and speech language and learning /health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may provide your health plan with medical information about the audiological and speech language and learning /health care services that the Northwestern University Center for Audiology, Speech, Language and Learning rendered to you for reimbursement purposes.
**Audiological/Health Care Operations**

We may use and disclose your protected health information for audiological and speech language and learning /health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to audiologists, speech language pathologists, physicians, nurses, technicians, medical students and other personnel for educational and learning purposes.

3. **Treatment Communications**

We may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which we or a business associate may receive financial remuneration in exchange for making the communication, we must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University Center for Audiology, Speech, Language and Learning, 2315 Campus Drive, Evanston, IL 60208.

4. **Fundraising Activities**

We may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Northwestern University Center for Audiology, Speech, Language and Learning. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to our Assistant Privacy Officer, Aaron Wilkins, NUCASLL, 2315 Campus Drive, Evanston, IL 60208.

5. **Others Involved in Your Healthcare**

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, we may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. We may also use and disclose protected health information to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

6. **Required by Law**

We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

7. **Public Health**

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also
disclose your protected health information, if directed by the public health authority, to a foreign
government agency that is collaborating with the public health authority.

8. Business Associates
We may disclose your protected health information to our business associates that perform
functions on our behalf or provide us with services if the information is necessary for such functions
or services. To protect your health information, however, we require the business associate to
appropriately safeguard your information.

9. Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may
have been exposed to a communicable disease or may otherwise be at risk of contracting or
spreading the disease or condition.

10. Health Oversight
We may disclose your protected health information to a health oversight agency for activities
authorized by law, such as audits, investigations, and inspections. Oversight agencies
seeking this information include government agencies that oversee the audiological and speech,
language and learning /health care system, government benefit programs, other government
regulatory programs and civil rights laws.

11. Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized
by law to receive reports of abuse or neglect. In addition, we may disclose your protected health
information if we believe that you have been a victim of abuse, neglect or domestic violence to the
governmental entity or agency authorized to receive such information. In this case, the disclosure
will be made consistent with the requirements of applicable federal and state laws.

12. Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food
and Drug Administration to report adverse events, product defects or problems, biologic product
deviations, track products to enable product recalls, to make repairs or replacements, or to
conduct post marketing surveillance, as required by law.

13. Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative
proceeding, in response to an order of a court or administrative tribunal (to the extent such
disclosure is expressly authorized), and in certain conditions in response to a subpoena,
discovery request or other lawful process.

14. Law Enforcement
We may disclose your protected health information, so long as applicable legal requirements are
met, for law enforcement purposes.

15. Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for
identification purposes, determining cause of death or for the coroner or medical examiner to
perform other duties authorized by law. We may also disclose your protected health information
to a funeral director, as authorized by law, in order to permit the funeral director to carry out its
duties. We may disclose such information in reasonable anticipation of death. Protected
health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
16. Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

17. Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your protected health information to prevent or lessen a serious threat to your health and safety or to the health and safety of another person or the public.

18. Military Activity and National Security
If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

19. Workers’ Compensation
We may disclose your protected health information as authorized for workers’ compensation or other similar programs that provide benefits for a work-related illness.

20. For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

21. Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION
Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION
The following uses and disclosures will be made only with your written authorization:

1. Uses and disclosures of protected health information for marketing purposes for which we or a business associate may receive remuneration; and
2. Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Northwestern University Center for Audiology, Speech, Language and Learning have taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.
YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. Right to be Notified if there is a Breach of Your Protected Health Information
You have the right to be notified upon a breach of any of your unsecured protected health information.

2. Right to Inspect and Copy
You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Northwestern University Audiology and Speech, Language and Learning Clinics use for making decisions about you. To inspect and copy your medical information, you must submit a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University Speech, Language and Learning Clinic, 2315 Campus Drive, Evanston, IL 60208. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our Assistant Privacy Officer, Aaron Wilkins, Northwestern University PERSONALISEDloffice@northwestern.edu if you have questions about access to your medical record.

3. Right to Request Restrictions
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University speech, Language and Learning Clinic, 2315 Campus Drive, Evanston, IL 60208. Your request must state the specific restriction requested and to whom you want the restriction to apply. Northwestern University Audiology and Speech, Language and Learning Clinics are not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiological and speech, language and learning /health care operation purposes and such information you wish to restrict pertains solely to a audiological and speech, language and learning /health care item or service for which you have paid us “out-of-pocket” in full. If we believe it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

4. Right to Request Confidential Communication
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must request this by submitting a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University Speech, Language and Learning Clinic, 2315 Campus Drive, Evanston, IL 60208.
5. Right to Request Amendment
You may request an amendment of your protected health information contained in your medical and billing records and any other records that NUCASLL use for making decisions about you, for as long as we maintain the protected health information. You must request for an amendment by submitting a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University Speech, Language and Learning Clinic, 2315 Campus Drive, Evanston, IL 60208, and provide the reason(s) that support your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. Right to an Accounting of Disclosures
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to our Assistant Privacy Officer, Aaron Wilkins, Northwestern University Speech, Language and Learning Clinic, 2315 Campus Drive, Evanston, IL 60208, and provide the reason(s) that support your request.

7. Right to Obtain a Paper Copy of this Notice
You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this Notice, you can contact our Assistant Privacy Officer, Aaron Wilkins, at (847) 491-3165 or NUCASLL@northwestern.edu. You may also obtain a copy of this Notice at www.communication/northwestern.edu/clinic.

COMPLAINTS OR QUESTIONS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with us, please contact our Assistant Privacy Officer, Aaron Wilkins, at (847) 491-3165 or NUCASLL@northwestern.edu or the Corporate Privacy Officer at the address listed below. All complaints must be submitted in writing. NUCASLL will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE
We reserve the right to change this Notice at any time. The new Notice will be effective for all health information we already have about you as well as any information we receive in the future. You can also obtain a revised Notice at www.communication.northwestern.edu/clinic or by contacting our Assistant Privacy Officer, Aaron Wilkins, NUCASLL, 2315 Campus Drive, Evanston, IL 60208.

Northwestern University Center for Audiology, Speech, Language and Learning
Attn: Corporate Privacy Officer

*This Notice is effective as of August 1, 2014*
Date Completed: _____________________
Child's name: ___________________________________________ Date of Birth: __________
Name of Person Completing Questionnaire: ________________________________
Relationship to Child: _____________________
Best Phone Number to reach parent completing form_________________________

Pediatrician Name __________________ Phone/Fax____________________

PARENTAL CONCERNS
When did you first become concerned about your child’s development? What were those concerns?

What are your current concerns about your child?

Has your child lost skills? (i.e. loss of words, eye contact, or any other developmental skills).

Yes No

If yes, please explain:

Do you have concerns about how your child does any of the following? Please check all areas of concern.

___ talks ___ understands ___ listens
___ sits ___ walks ___ runs
___ plays with toys ___ interacts with others ___ plays with other children
___ learns ___ behaves ___ reacts to movement
___ reacts to sounds ___ reacts to touch

Are you concerned or have you ever thought about your child having any of the following diagnoses? Please check all areas of concern.

___ Anxiety Disorder
___ Attention Deficit Hyperactivity Disorder
___ Apraxia of Speech
After your visit at the Developmental Diagnostic Clinic, what questions do you hope will be answered?

**BEHAVIOR**

Circle the words that describe your child today:

<table>
<thead>
<tr>
<th>Easy-Going</th>
<th>Nervous</th>
<th>Happy</th>
<th>Brave</th>
<th>Active</th>
<th>Slow to Adjust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explosive</td>
<td>Shy</td>
<td>Fearless</td>
<td>Flexible</td>
<td>Likes Sameness</td>
<td>Fearful</td>
</tr>
<tr>
<td>Clingy</td>
<td>Busy</td>
<td>Quiet</td>
<td>Unpredictable</td>
<td>Cranky</td>
<td>Social</td>
</tr>
<tr>
<td>Loud</td>
<td>Independent</td>
<td>Friendly</td>
<td>Cuddly</td>
<td>Aggressive</td>
<td>Playful</td>
</tr>
</tbody>
</table>

What are your child’s strengths?

What are your child’s challenges?

How does your child calm him/herself when he/she is upset?

What methods of limit setting do you use in your home, if applicable?

What methods of limit setting work best with your child?

How often do you need to set limits with your child?

**MEDICAL, SCHOOL, OR THERAPIST REPORTS**

What past medical/school or therapy evaluations has your child had?

- ___ Neurologist
- ___ GI (stomach) doctor
- ___ Social worker
- ___ Psychiatrist
- ___ Orthopedic doctor
- ___ Occupational therapist
- ___ Psychologist
- ___ Developmental Pediatrician
- ___ Speech therapist
- ___ Genetics doctor
- ___ Endocrinologist
- ___ Physical Therapist
- ___ Rehabilitation doctor
- ___ Cardiologist
- ___ Behavior Therapist
- ___ Complementary/alternative provider
- ___ Other health care provider
What medical tests has your child had, and what were the results?

Chromosomes
Fragile X
Microarray
Lead
Other blood testing, please list

MRI of brain
CT scan of brain
EEG
Bone x-ray
Other imaging, please list

How often does your child receive the following therapies?

__ Physical Therapy ________ Individual _______Group
__ Occupational Therapy ________ Individual _______Group
__ Speech and Language Therapy ________ Individual _______Group
__ Developmental Therapy ________ Individual _______Group
__ Other, Please list ________ Individual _______Group

When did your child first start receiving therapies?

Early intervention:_________________________________
Occupational Therapy:_____________________________
Physical Therapy:_______________________________
Speech/Language:_______________________________
Preschool:_______________________________________
Behavioral:_____________________________________
Feeding:________________________________________
Other:_________________________________________

Have any of these services been discontinued? List dates and service below.

Has your child ever been diagnosed with a motor speech disorder such as apraxia or dysarthria? __Yes __No __Unsure

Has your child ever been taught to use any augmentative modes of communication (sign language, speech output devices, PECS, etc.)? __Yes __No __Unsure

If yes, list here___________________________________________________________

Have you ever received any parent training in speech, language, or behavioral techniques?\ __Yes __No __Unsure

If yes, list here____________________________________________________________
Please list all the services your child is currently receiving.

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Name/Organization</th>
<th>Number of hours received/wk</th>
<th>Intervention done as a group or individually</th>
<th>Where is the intervention delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General early intervention provider</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Preschool</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Behavioral Therapy</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Feeding Therapy</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
<td>□ Ind. □ Grp. □ Home □ School □ Clinic</td>
</tr>
</tbody>
</table>

Describe what is going well.

Describe what could be going better.

**BIRTH HISTORY**

Were there any problems with the pregnancy? Yes No Unsure
If yes, please describe:

Were there any problems with labor and delivery? Yes No Unsure
If yes, please describe:
What type of delivery did the mother have?

What was your child’s birth weight?

Was your child premature? Yes No If yes, by how many weeks? ____

How long was the baby in the hospital after birth?

Were there problems with the baby or mother in the hospital after birth? Yes No If yes, please describe:

Circle the words that best describe your child as an infant:
Happy  Fussy  Irritable  Cuddly  Quiet
Demanding  Easy Going  Angelic  Cranky  Sleepy
Active  Observant  Difficult to console  Quiet

GENERAL HEALTH
Who is your child’s Primary Physician?
Name:________________________________________________________________________
Address: _______________________ City________________ Zip Code ___________________
Phone: (____) _____________________ Fax: (___)____________________________________

When was the last time your child was seen by his/her primary physician?

Are the child’s immunizations up to date? Yes No If not, why?

Does your child have any allergies? Yes No If yes, please describe:

Does your child have any chronic medical conditions? Yes No If yes, please describe:

Has your child had any accidents or injuries? Yes No If yes, please describe:

Has your child been hospitalized? Date:
Illness:
Hospital:

Has your child had surgery? Date:
Illness:
Hospital:
Does your child take medication regularly?  
Yes  No  
If yes, please list with dosage and frequency required:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>

Has your child’s hearing been tested?  If so, when and what were the results?  

Has your child’s vision been tested?  If so, when and what were the results?  

Do you have any concerns about your child’s sleep?  If so, please describe.  

Do you have any concerns about your child’s eating?  If so, please describe.  

**FAMILY AND SOCIAL HISTORY**  
Has anyone in the family had (include aunts, uncles, grandparents, and cousins):

<table>
<thead>
<tr>
<th>Disorder</th>
<th>YES</th>
<th>NO</th>
<th>If YES Who:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures / Epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Asperger Syndrome</td>
<td></td>
<td></td>
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<tr>
<td>Intellectual Disability</td>
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<tr>
<td>Developmental Delay</td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Speech Problems</td>
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</tr>
<tr>
<td>Learning Problems in School</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Attention Deficit/Hyperactivity Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Birth Defects</td>
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<td></td>
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<tr>
<td>Thyroid Problems</td>
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<td></td>
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<tr>
<td>Tics or Tourette syndrome</td>
<td></td>
<td></td>
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<tr>
<td>Alcoholism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>YES</td>
<td>NO</td>
<td>If YES Who:</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<tr>
<td>Drug Abuse</td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Manic Depression/Bipolar Disorder</td>
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</tr>
<tr>
<td>Anxiety Disorder/Panic Attacks</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Obsessive Compulsive Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
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<td></td>
<td></td>
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<tr>
<td>Hearing loss</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Miscarriages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic Syndromes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are there any other medical conditions that run in the child’s family which you think are important to share with us?**

Is the child’s mother in good health?  
Yes  No
If no, please describe:

Is the child’s father in good health?  
Yes  No
If no, please describe:

**Social History**
Other children in household:
Adults in household:
Name  Age  Relationship  Name  Relationship

Do you have any concerns about the health, growth and development of the other children?

Do any of the other adults have serious health concerns?

Are there legal issues we should know about your child (custody, DCFS, adoption, etc.)
What languages are spoken in the home?

Who cares for your child during the day?

Have friends or relatives expressed concern about your child’s development?  
If so, who and what are their concerns?

Has your child attended daycare or nursery school?  
Yes  No
If yes, where?

Was it a positive experience?  
Yes  No
Please explain:

Please list other types of community services/activities in which your child participates (parent support group, community play group, park district programs):

What is the child's mother's education?  
___ Grade School  ___ Some High School  ___ High School
___ Some College  ___ College  ___ Trade School
___ Graduate / Professional Degree

What is father’s education?  
___ Grade School  ___ Some High School  ___ High School
___ Some College  ___ College  ___ Trade School
___ Graduate / Professional Degree

What is the mother's occupation?  

What is the child's father’s occupation?

What is your child’s race and ethnicity?  
___ Prefer not to answer  ___ Prefer not to answer
___ Hispanic or Latino  ___ American Indian or Alaskan Native
___ Not Hispanic or Latino  ___ Asian
___ Native American or Pacific Islander  ___ Black or African American
___ White  ___ Other

Are there any other concerns or challenges affecting your family? (Please √ below).
___ Financial Concerns  ___ Relationship Problems
___ Employment Concerns  ___ Violence (Past or Present)
___ Housing  ___ Substance use or addictions
___ Caring for other family members  ___ Lack of support resources
___ Other
Please explain:
OTHER HEALTH:
Has your child had any of the following symptoms? (Please check all that apply):

___ Poor appetite       ___ Excessive appetite       ___ Poor growth
___ Rapid weight gain   ___ Hearing problem       ___ Vision problem
___ Seizures           ___ Staring spells         ___ Fainting
___ Coordination problems ___ Developmental delay ___ Speech delay
___ Repetitive movements ___ Tics                 ___ Muscle weakness
___ Loose muscles (low tone) ___ Tight muscles (high tone) ___ Tremors
___ Hoarseness          ___ Difficulty swallowing ___ Loud snoring
___ Chronic cough       ___ Shortness of breath   ___ Wheezing
___ Heart murmur        ___ Heart problems       ___ Frequent diarrhea
___ Frequent vomiting    ___ Stomach pain        ___ Constipation
___ Frequent fevers      ___ Frequent ear infections ___ Sinus problems
___ Chronic nasal congestion ___ Eczema             ___ Rashes
___ Teeth problems      ___ Hair problems

Is there anything else you would like us to know about your child's health, development, and behavior?

Thank you very much for completing the form. It will help us understand your concerns about your child and how we may best help you.
<table>
<thead>
<tr>
<th>M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank you very much.</td>
</tr>
<tr>
<td>1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)</td>
</tr>
<tr>
<td>2. Have you ever wondered if your child might be deaf?</td>
</tr>
<tr>
<td>3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)</td>
</tr>
<tr>
<td>4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)</td>
</tr>
<tr>
<td>5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)</td>
</tr>
<tr>
<td>6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)</td>
</tr>
<tr>
<td>7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)</td>
</tr>
<tr>
<td>8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)</td>
</tr>
<tr>
<td>9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)</td>
</tr>
<tr>
<td>10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)</td>
</tr>
<tr>
<td>11. When you smile at your child, does he or she smile back at you?</td>
</tr>
<tr>
<td>12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)</td>
</tr>
<tr>
<td>13. Does your child walk?</td>
</tr>
<tr>
<td>14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?</td>
</tr>
<tr>
<td>15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)</td>
</tr>
<tr>
<td>16. If you turn your head to look at something, does your child look around to see what you are looking at?</td>
</tr>
<tr>
<td>17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say “look” or “watch me”?)</td>
</tr>
<tr>
<td>18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?)</td>
</tr>
<tr>
<td>19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)</td>
</tr>
<tr>
<td>20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)</td>
</tr>
</tbody>
</table>