MŌHALU Therapy℠

CHILD'S INFORMATION

Name _____ Date _____

Birthdate _____ Gender *M* *F* Grade _____

Address _____

City _____ State _____ Zip code _____

Emergency contact/relationship _____ Phone _____

Individual(s) that we may also communicate with _____ Relationship _____

Primary care physician _____ Phone _____

Referral physician (if different) _____ Phone _____

Parent/Guardian name _____ P/G age _____

Parent/Guardian name _____ P/G age _____

Parent's marital status _____

Others living in child's home *(name, age, relationship)* _____

PARENT OR GUARDIAN INFORMATION

Person completing this form _____ Relationship to child _____

Email _____ Primary phone _____ Other phone _____

Preferred communication *(check all that apply)*	❑ *Voicemail*	❑ *Text*	❑ *Email*

How did you hear about **MŌHALU Therapy**? _____

SYMPTOMS AND TREATMENT

Primary complaint/reason for visit: _____

_____

Describe the child's current speech/feeding difficulties. _____

_____

What school/daycare does the child attend? _____

Is the child enrolled in special education classes? _____

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What school-based speech services has the child received? _____

_____

Comments about the child's school: _____

_____

Describe family members' similar or other speech/feeding difficulties. _____

_____

At what age did the following occur?

_____ Said 1st words

_____ Crawled

_____ Walked unaided

_____ Toilet trained

Does the child appear clumsy or awkward? _____

Has the child received any intervention or therapy for motor development? _____

What is the child's communication at the present time? *(check all that apply)*

- ❑ Grunts and points
- ❑ Screams
- ❑ Gestures
- ❑ Takes you to object
- ❑ Copies what you do
- ❑ Copies what you say
- ❑ Single words
- ❑ Two-word phrases
- ❑ Longer sentences
- ❑ Unclear speech
- ❑ Stutters
- ❑ Too soft
- ❑ Too loud
- ❑ Hoarse
- ❑ Other _____

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List the child's current medications and reason(s) prescribed.

_____

_____

Describe the child's allergies or sensitivities (e.g. latex, lotion, scents, foods, medications).

_____

_____

List the child's previous evaluation or therapy (e.g. speech pathologists, physicians, other professionals)

Name	Address	Date(s)

Length of mother's pregnancy _____ Length of mother's labor _____

Describe any complications during delivery _____

Which of the following did the child's mother experience during pregnancy? *(check all that apply)*

- ❑ X-rays
- ❑ Medication
- ❑ Chicken pox
- ❑ Drug/alcohol use
- ❑ Surgery
- ❑ Toxemia
- ❑ Measles
- ❑ Accidental injury
- ❑ Accidents _____
- ❑ Infections _____
- ❑ Illnesses _____

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Did the child experience any of the following conditions immediately after birth? *(check all that apply)*

- ❑ Breathing difficulties
- ❑ Jaundice
- ❑ Infections
- ❑ Sucking/swallowing problems
- ❑ Oxygen needed
- ❑ Seizures
- ❑ Feeding problems
- ❑ Bleeding

Any abnormalities or conditions not yet mentioned? _____

Does the child have a history of the following? *(check all that apply)*

- ❑ High fever
- ❑ Asthma
- ❑ Head injuries
- ❑ Operations
- ❑ Eating/swallowing problems
- ❑ Wears a hearing aid
- ❑ Ear infections
- ❑ Frequent colds
- ❑ Hospitalizations
- ❑ Medications
- ❑ Wears glasses
- ❑ Behavioral problems
- ❑ Seizures
- ❑ Allergies
- ❑ Illnesses
- ❑ ADD/ADHD diagnosis
- ❑ Hearing problems

Please explain the items checked above _____

_____

Describe any physical disability or condition _____

_____

Treatment Guidelines and General Information —For Parents/Guardians

Please read this section and sign the final page. If you have any questions or concerns, please let me know at or before the child's first appointment.

What to have for the 1st visit.

For the child's first visit, have (1) a speech therapy script or physician order, if you have one; (2) copies of any imaging studies related to the child's treatment; and (3) this completed packet, unless you emailed it to me.

Communication.

The child benefits the most from our relationship when your family asks questions or candidly tells me about the child's symptoms, progress, or concerns. Whether paper or electronic, the child's files will be stored in a safe and secure manner. I will send information to you (parent or guardian) electronically, unless you request otherwise. To communicate efficiently, I may email, text, or call based on your preferences. These technologies may not be secure, so by signing below, you waive any objection to communication between us via these methods.

Cancellations and Missed Appointments.

If you need to change or cancel an appointment, I appreciate as much notice as possible so I can offer your appointment time to another patient on the waiting list. I require at least 24 hours' notice for all cancellations and schedule changes. Otherwise, you'll be charged in full for the missed appointment. Also, if you're more than 15 minutes late for your appointment, I have the right to cancel the appointment and charge in full for the missed appointment. And I may put your services on hold if you don't attend, cancel, or arrive 15 minutes late for 3 sessions in a row.

Payment and Insurance.

Full payment is due before each session. **MŌHALU Therapy** doesn't contract with any insurance companies and therefore is an out-of-network, non-participating provider. However, you may be reimbursed by your insurance company, depending on your plan. Please contact your insurance company or employer for information about how to submit a claim or proof of payment for HSA or FSA reimbursement.

Privacy.

MŌHALU Therapy protects the child's privacy and only uses or discloses his/her confidential health information (in verbal or written form) for services or treatment; reporting, collaborating, or communicating with the child's physician(s) or other treatment provider(s); administrative activities; or payment. The child's personal health information may be disclosed without prior authorization in an emergency or when required by law. In all other situations, your (or a lawful parent or guardian) written authorization or consent will be obtained before the child's personal health information is disclosed. If you give written authorization, you may later revoke that

authorization at any time or for any reason. You have a right to obtain a copy of the child's personal health information at any time, or request that inaccurate or incomplete information be corrected.

I read, understand, and voluntarily agree to these Treatment Guidelines. I have the legal right to act on behalf of the child who will be treated, including the right to authorize treatment. I voluntarily consent to the child's evaluation, care, and treatment by **MŌHALU Therapy**, as recommended or as prescribed by the child's physician or provider. I understand my right to ask questions, stop treatment, or receive information about the purpose, benefits, risks, or alternatives to treatment. Although treatment is usually beneficial, I acknowledge that no guarantees or promises about results or outcomes have been made to me or the child because treatment is not an exact science. I accept responsibility for candidly communicating about the child's health, medications, allergies, symptoms, treatment, or progress. I give permission to **MŌHALU Therapy** to use or release the child's personal health information for services or treatment; reporting, collaborating, or communicating with the child's physician(s) or other treatment provider(s); administrative activities; or payment. I understand that I am responsible to pay for the child's treatment, and I have information about service fees.

Parent/Guardian Signature: _____

Date: _____

Thank you for choosing MŌHALU Therapy

I look forward to working with you!

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