Identifying and Family Information

Child's Name: _____ Date of Birth: _____
Sex: M F
Age:

School or Childcare: _____
Teacher: _____

Is your child presently under the care of another SLP at school or in the community? Yes No
Name of SLP: _____

Mother's Name: _____ ___ Daytime Phone: _____
Address: _____ ___ Cell Phone: _____
E-mail: _____

Father's Name: _____ ___ Daytime Phone: _____
Address: _____ ___ Cell Phone: _____
E-mail: _____

Does the child live with both parents: Y N
Who has custody: _____

Doctor's Name: _____ Doctor's Phone: _____

Is there a language other than English spoken in the home? Yes No
If yes, what language?
_____
Does the child speak the language? Yes No
Does the child understand the language? Yes No

Which language does the child prefer to speak at home?
_____

What are the child's interests? What do they enjoy?
_____
_____

Medical History

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please describe.

_____

_____

Has your child had any of the following?

- Adenoidectomy
- Seizures
- Flu
- Breathing Difficulties
- Sleeping Difficulties
- High Fevers
- Colds
- Tonsillectomy
- Tonsillitis
- Vision Problems

Encephalitis
Allergies
Sinusitis
Head Injury
Chicken Pox
Thumb/Finger Sucking Habit
Meningitis
Ear Infections
Ear Tubes

Other serious injury/surgery:

_____

Has your child been diagnosed with any of the following?

Please write the year the diagnosis was made. _____

Attention Deficit Disorder	Central Auditory Processing Disorder	Sensory Integration Disorder
Attention Deficit Disorder with Hyperactivity	Down Syndrome	Specific Learning Disability Reading, Written Expression, and/or Math
Epilepsy	Autism	Asperger's Syndrome
Behavior or Emotional Disorder	Pervasive Developmental Disorder	Developmental Delay

Other _____

Is your child currently (or recently) under a physician's care? Yes No

If yes, why?

_____

_____

Please list any medications your child takes regularly:

_____

Are there any precautions that should be taken with the child?

_____

Has your child had a hearing test? Yes No

When: _____ What were the results?

Please describe any pertinent family history of speech, language and learning difficulties (i.e. mother, father, siblings, and grandparents):

_____
_____
_____
_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ babbled
_____ toilet trained
_____ used single words meaningfully
_____ sat alone
_____ began combing words meaningfully
_____ walked
_____ spoke in short sentences

Did your child breastfeed? Yes No Did your child take a bottle? Yes No.
For how long did they breast feed? _____
For how long did they use a bottle? _____
Any challenges feeding within the first three months of life?

Did your child use a pacifier or suck his/her thumb? Yes No

Does your child…

- choke on food or liquids?
- currently put toys/objects in his/her mouth?
- brush his/her teeth and/or allow brushing?

Is your child a picky eater?

If yes, what foods do they prefer? Avoid?

Check all that apply
Does your child…

- repeat sounds, words or phrases over and over?

- understand what you are saying?

- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions (“Shut the door” or “Get your shoes”)?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?

Check all that apply
Your child currently communicates using...

- body language (pointing, looking, gesturing).
- sounds (vowels, grunting).
- words (shoe, doggy, up).
- 2 to 4 word sentences.
- sentences longer than four words.
- other _____

How much of what your child says do you understand?

How much of what your child says do unfamiliar listeners understand?

What are your child’s strengths?

What are your child’s areas of growth?

Please describe your concerns at this time:

CONSENT FORM

I/We _____ are the guardian of _____ and hereby give my/our permission and the authorization to (therapist) _____for:

- ☐ provide intervention for: _____
- ☐ contact us via telephone regarding scheduling, goals/progress and issues related to our care
- ☐ contact us via e-mail regarding scheduling, goals/progress and issues related to our care

The benefits of intervention have been explained to me and include:

_____

_____

The risks and side effects have been explained to me and include:

_____

_____

Alternatives to the recommended intervention include:

_____

_____

As the legal guardian, I have initialed the Agencies/Organizations/Therapists below which I consent to have the disclosure of information:

- ☐ Any Physicians _____
- ☐ Community Care Access Centre – Waterloo Region
- ☐ Waterloo Region District School Board
- ☐ Waterloo Catholic District School Board
- ☐ Therapist _____
- ☐ Other _____

_____ _____

Signature of the parent/guardian Date

_____ _____

Therapist Date

For Collection, Use and Disclosure of Personal Information

Providing quality treatment includes protecting the privacy of your personal information. It is an essential part of our service to you and your family. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our clients.

AT SPEAK YOUR MIND THE PRIVACY INFORMATION OFFICER IS:
BRIAR CIPRYK

All volunteers or supportive personnel who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our clinic is doing to ensure that

- only necessary information is collected about you and your child
- we only share your information with your consent
- storage, retention and destruction of your child's personal information complies with existing legislation, and privacy protocols
- our privacy protocols comply with privacy legislation, standards of our regulatory body CASLPO and the law.

Do not hesitate to discuss our policies with me. Please be assured that every member in the clinic is committed to ensuring that your information is kept confidential.

How Speak your Mind Collects, Uses And Discloses Clients' Personal Information

- to identify and to ensure continuous high quality service
- to assess your child's communication development
- to advise you of treatment options
- to enable us to contact you
- to establish/maintain communication with you via telephone, newsletters, postcard reminders etc.
- to offer and provide treatment, care and services
- to communicate with other treating health-care providers, including community therapists, teachers and referring doctors (with your permission)
- to allow us to maintain communication and contact with you to distribute home programs, treatment amendments, and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing

- for teaching on an anonymous basis
- to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of clients' chart and records in a timely fashion for regulatory and monitoring purposes
- to invoice for goods and services
- to process payments (cheque)
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this client consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your child's personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Speak Your Mind will not under any conditions supply your insurer with your child's confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Client Consent
I have reviewed the above information that explains how your clinic will use my child's personal information, and the steps your clinic is taking to protect my child's information information.

I _____ allow BRIAR CIPRYK to collect, use and disclose personal information about my child, as set out above in the clinic's privacy policies.

Signature _____ Print Name_____

Date_____ Signature of Witness_____