



# Harpers Heart's LLC, Lisa H. McCall M.S., CCC-SLP

## Patient Information

All information obtained on this form will be confidential. Patient information is needed for implementing the most appropriate therapy services.

### PATIENT INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone (h) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Address: \_\_\_\_\_  
(street number) (city) (zip)

Name of school or preschool: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name of Pediatrician & Practice: \_\_\_\_\_

Please describe your specific concerns:  
\_\_\_\_\_  
\_\_\_\_\_

Please list family members living in the home: \_\_\_\_\_

Please list any other languages spoken in the home: \_\_\_\_\_

Was the patient born premature? \_\_\_\_\_ If so, at how many weeks? \_\_\_\_\_

Describe a typical day for your child (ex: at home, attends daycare, school, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If your child is not yet talking, how does he/she communicate his/her wants and needs (ex: pointing, leading you by the hand, etc):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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### **MEDICAL AND DEVELOPMENTAL HISTORY:**

List any hospitalizations, surgeries, or serious illnesses along with the date of occurrence:

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Does your child have a history of ear infections? If so, please explain:

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Please list the approximate age of your child when he/she achieved the following milestones:

_____ babbled	_____ said first words	_____ combined words
_____ crawled	_____ walked	_____ stood
_____ sat up	_____ fed self	_____ toileted

Does your child have any feeding difficulties? \_\_\_\_\_

List any medications your child is currently taking:

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List any previous screenings or evaluations your child has received and when:

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Has your child received any previous therapies (if so, please explain):

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List any diagnosis that has been given to your child:

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Does your child currently have an IEP/IFSP (if so, please bring to initial visit):

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Does your child appear to be aware of or frustrated by any speech or language difficulties?

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**PARENT INFORMATION:**

Parent Name(s): \_\_\_\_\_

Date(s) of Birth: \_\_\_\_\_

Phone: (h): \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_

Address: (if different) : \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

In case of emergency contact:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE INFORMATION: (Blue Cross Blue Shield /Cigna - ONLY)**

Insured ID Number \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured Policy Group \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_

**For all other Insurance carriers, currently Harper's Hearts does not file insurance. Payment is the responsibility of the parent at the time of therapy. I am happy to provide you and your family with the codes you will need to get reimbursement from your insurance company. Payment is accepted in Visa, MasterCard, American Express, HSA and FSA Cards, check or cash.)**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_