



Child's Name: _____ Date of Birth: _____
 Parent's Name(s): _____ Referred by: _____
 Address: _____
 Phone: _____ Alternative Phone: _____
 Best time to call: _____ Email: _____
 Form completed by: _____ Date: _____

Pre-Assessment Questionnaire

Physical Development:

- At what age did the child: (age in months)
 Sit alone: _____
 Walk alone: _____
 Toilet train: _____
 First word(s): _____
- Is the child right or left handed? _____

Medical History:

- Has the child had:

Disease/Condition	Date
Chicken Pox	
Measles	
Mumps	
Scarlet Fever	
Ear Infections	

- Has the child ever been hospitalized? Yes No
 If yes, please explain _____
- Has the child ever had a serious injury or surgery? Yes No
 If yes, please explain _____
- Is the child currently taking any medications? Yes No
 If yes, please list _____

Hearing

- Do you suspect a hearing problem? Yes No
 If yes, why? _____
- Has the ever had his/her hearing tested? Yes No
 If yes, when? _____ Results _____

Birth History

1. Was the pregnancy full term? Yes No
If no, explain? _____
2. Was the mother healthy during her pregnancy? Yes No
If no, explain? _____
3. Age of mother at time of delivery _____
4. Length of labor _____
5. Was the delivery:
Normal _____
Breech _____
C-Section _____ If C-Section, why? _____

6. Were there any complications during delivery? Yes No
If yes, explain? _____
7. Birth weight _____
8. Condition of child at birth _____
9. Any problems with the child during the first few month of life

Educational History

1. Present school? _____
2. Present grade? _____
3. Present teacher? _____
4. Special services? _____
5. Year child started school? _____
6. Does the classroom teacher report any difficulties Yes No
If yes, please describe _____

7. Are school grades:
___ Superior
___ Average
___ Below Average
8. Best Subjects _____
9. Weak Subjects _____

Social History

1. Who lives in the home with the child?

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Who, besides parents, cares for the child?

3. Describe the child's personality?

4. How does the child get along with:

Siblings _____

Adults _____

Peers _____

5. Do you have any concerns about the child's development?

Physicians

Please list any physicians who are currently treating your child

Name

Specialty

_____	_____
_____	_____
_____	_____
_____	_____

Therapists and Other Professionals

Please list any other professionals who are currently working with your child

Name

Specialty

_____	_____
_____	_____
_____	_____
_____	_____



Fee Schedule
Effective June 1, 2008

SERVICE	FEE
Speech-Language Evaluation	\$350.00
Occupational Therapy Evaluation	\$350.00
Two Discipline Comprehensive Evaluation	\$650.00
Speech-Language treatment session or consultation	\$120.00
Occupational Therapy treatment session or consultation	\$120.00
Infant Development Specialist (IDS)/Special Education treatment session or consultation	\$120.00
Nutrition Services treatment session or consultation	\$120.00
Social Work treatment session or consultation	\$120.00
Group Speech or Occupational Therapy Session (per hour/per child)	\$100.00
Re-Assessment Evaluation	\$300.00
Team Meeting Attendance (per hour)	\$120.00
Non-Treatment Home Program Documents & Resources	\$50.00
Photo Copies of Medical Records (beyond 5 pages)	\$15.00

Evaluations include written reports and initial consultations and vary in length depending on individual child's needs.

Treatment sessions or consultations range in length from 45 minutes to 1 hour as determined by the therapist.

Cancellation Policy: Cancellations made less than 24 hours in advance are billed at the full rate of scheduled service with the exception of emergency situations and illnesses. We appreciate your efforts to notify us as early as possible if there is to be a cancellation.

Payment Information: Payment is due at the time that services are rendered. Spectrum Pediatrics, LLC does not accept payment from third party providers (i.e. health insurance companies, school districts, counties).



Payment Agreement

I, _____ (parent/guardian), acknowledge and accept full and complete responsibility for prompt payment of all services rendered to _____ (child/client) by Spectrum Pediatrics, LLC. Prompt payment must be received at the time services are rendered to the child mentioned above. I acknowledge that I have received written explanation of the fee structure and the cancellation policy and I agree to both.

The fees that I am charged by Spectrum Pediatrics, LLC are in no way related to health insurance or educational reimbursement. I understand that I am personally responsible for direct payment to Spectrum Pediatrics, LLC, regardless of any reimbursement issues that I choose to investigate.

SIGNATURE (parent or legal guardian)

DATE



Consent for Services

I, _____ (parent/guardian), give my permission to Spectrum Pediatrics, LLC to exchange information about _____ (child/client) with the following physicians, programs, and other persons:

I also give permission to Spectrum Pediatrics, LLC to provide evaluation, treatment, and consultative services to the above mentioned child.

I understand that fees for services provided are due at the time of treatment.

Parent/Legal Guardian

Date

Witness

Date