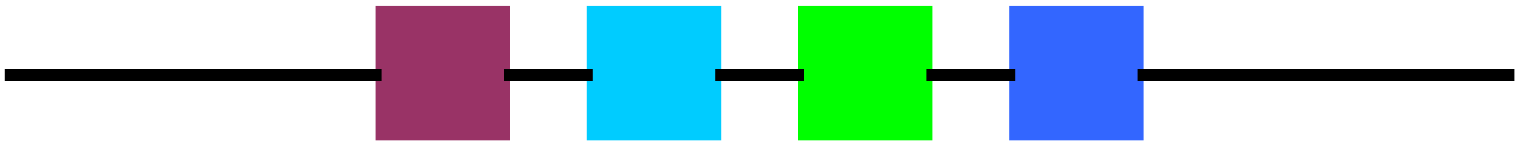

ALLISON THERAPEUTICS, LLC

Case History Questionnaire

Patient's Name: _____ Date: _____
First Middle Last

Date of Birth: _____

Caregiver's Name_____ Relationship to Child _____

Address _____

_____
City State Zip

Home Phone: _____ Alternate Phone: _____
Email: _____

What language(s) is/are spoken in the home?_____Primary_____
Who lives in the home? _____

INSURANCE
Insurance Company _____Policy #_____
Name on Policy _____ Insured's Birthdate_____

REFERRAL
How did you hear about Allison Therapeutics, LLC? _____

ACADEMIC INFORMATION

_____ Phone: _____
School

_____
Address

_____ _____
Teacher Grade

Briefly indicate how well your child functions in school _____

1233 Ben Sawyer Blvd, Ste 500
Mount Pleasant, SC 29464
ph-843-697-0396
fax-803-675-0787
jenni@allisontherapeutics.com

_____

_____

MEDICAL INFORMATION

Physician _____ Phone: _____

Address _____

_____

Has your child received any other Speech-Language Pathology services? _____

With whom? _____

How long? _____

Please mark if your child has or has ever been diagnosed with any of the following:.

- ❑ Asthma
- ❑ Autism
- ❑ Congenital Heart Disease
- ❑ Cerebral Palsy
- ❑ Gastro-intestinal issues
- ❑ Brain Injury or Trauma
- ❑ Tracheal malasia
- ❑ Tracheostomy
- ❑ Cleft Lip
- ❑ Cleft Palate
- ❑ Hearing Impairment
- ❑ Malnutrition
- ❑ Genetic Syndrome
- ❑ Downs Syndrome
- ❑ Pierre Robin Syndrome
- ❑ Prader-Willi Syndrome

SPEECH AND LANGUAGE INFORMATION

Speech

What percentage of your child's speech is understandable to family members? _____

to unfamiliar people? _____

Briefly describe your child's speech as you perceive the errors _____

_____

_____

Rate

Please mark those that apply.

- ❑ Rapid speech
- ❑ Stuttering behaviors
- ❑ Involuntary tics, Repetitive sounds
- ❑ None of the above

Language

Does your child understand more than he/she can say? _____

Does your child consistently use specific sounds to designate certain objects, people or things?

_____

History

Is your child aware of your speech concerns? _____

Does he/she have concerns about his/her own speech? _____

If so, how does this affect his/her social interactions and/or academic performance? _____

_____

_____

FEEDING INFORMATION

Does your child demonstrate strong preferences and aversions to particular foods? _____

If so, please specify. _____

_____

Briefly describe concerning behaviors involving feeding _____

_____

_____

_____

ADDITIONAL INFORMATION

Please provide any further information you feel is relevant to your child's speech, language and feeding performance.

_____

_____

_____

_____

_____

Please attach any files from schools or physicians that you feel are relevant to this issue.

Thank you for contacting Allison Therapeutics, LLC for your speech-language and feeding concerns.

Patient's Full Name: _____

Date of Birth: _____

Patient Signature (or signature of legal guardian): _____

Date: _____