

Date \_\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name \_\_\_\_\_ Patient's First Name \_\_\_\_\_ Patient's Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_ Preferred name \_\_\_\_\_

Male    Pronouns:  He/Him     She/Her     They/Them     Another \_\_\_\_\_  
 Female

Race:  Caucasian (White)  American Indian  African American (Black)  Hispanic  Asian  Multiracial  Other

Ethnicity:  Hispanic/Latino  Non-Hispanic/Non-Latino  Refused/Declined    Primary Language: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mail to address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 (If different from home address)

Home Phone: ( ) \_\_\_\_\_  This is the primary number for patient.    Cellphone: ( ) \_\_\_\_\_  This is the primary number for patient.

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

### EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION (Pediatric patients only)

**Parent/Guardian 1** (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_

Date of birth: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
 Month/Day/Year

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 (If different from the patient)

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

**Parent/Guardian 2** (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_

Date of birth: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
 Month/Day/Year

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 (If different from the patient)

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

### RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
 (If different from the patient) (If different from the patient)

Mail to address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 (If different from the patient)

Social Security Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

Check here if no insurance. Skip to authorizations (below).

**PRIMARY INSURANCE INFORMATION (Please present insurance card and ID to Business Office)**

**Subscriber:** This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: \_\_\_\_\_ Subscriber's date of birth: \_\_\_\_\_  
Month/Day/Year

Patient relationship to subscriber: \_\_\_\_\_

**If address and phone number is same as patient, please indicate same.**

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Insurance co. name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy/Cert #: \_\_\_\_\_ Group no.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (Please present insurance card and ID to Business Office)**

**Subscriber:** This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: \_\_\_\_\_ Subscriber's date of birth: \_\_\_\_\_  
Month/Day/Year

Patient relationship to subscriber: \_\_\_\_\_

**If address and phone number is same as patient, please indicate same.**

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Insurance co. name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy/Cert #: \_\_\_\_\_ Group no.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**AUTHORIZATIONS**

*I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment services provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.*

Signature \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date \_\_\_\_\_

**ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY**

*I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insurance coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.*

*If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).*

Signature \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date \_\_\_\_\_

**LATE CANCELLATION AND NO-SHOW POLICY**

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at (864) 331-1400 to cancel or reschedule. If two appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment after a six-month waiting period from the time of the missed appointment.*

Signature \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date \_\_\_\_\_



## Privacy Practices and Authorization for Disclosure of Medical Information

The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

### PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: \_\_\_\_\_

### SHARING INFORMATION WITH OTHERS

Please **CHECK** the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

- Results of Evaluations       Appointment Information       Billing Information       Treatment Information

\_\_\_\_\_  
Name of person that has permission to receive the above patient information      Relationship to Patient

\_\_\_\_\_  
Name of person that has permission to receive the above patient information      Relationship to Patient

### COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check **ONLY ONE**

- All Information including appointments, general information, updates, billing etc.  
 Appointment information **ONLY**

(    ) \_\_\_\_\_  
Phone Number      Relationship to Patient

### COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

- Results of Evaluations       Appointment Information       Billing Information       Treatment Information

\_\_\_\_\_  
Email Address      Name of the account owner for this email address      Relationship to Patient

\_\_\_\_\_  
Email Address      Name of the account owner for this email address      Relationship to Patient

### RIGHTS OF THE PATIENT

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

**I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.**

\_\_\_\_\_  
Signature      Relation to Patient      Date



## HIPAA Notice of Privacy Practices

Effective as of April 14, 2003  
Revised November 16, 2018  
Contact: (864) 331-1400

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*This Notice of Privacy Practices is not an authorization. The Notice of Privacy Practices describes, how we our Business Associates and their subcontractors, may use and disclose protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (also referred to as PHI) is health information is information about you, including demographic information, that may identify you and that relates to your past present, or future physical or mental health care condition and related health care needs.*

#### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of Clarity, Inc., and any other use required by law.

**Treatment-** We may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

**Payment-** We may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

**Health Care Operations-** We may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. We may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. We may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business. We may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

**Fundraising-** We may contact you for our **own** fundraising activities. If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

#### **USES AND DISCLOSURE THAT REQUIRE YOUR AUTHORIZATION**

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

**Uses or Disclosures for Psychotherapy Notes-** We will require written authorization for most uses and disclosures of psychotherapy notes, where applicable.

**Uses or Disclosures for Marketing Purposes-** We will require an authorization for uses and disclosures of protected health information used in marketing.

**Disclosures for a Sale of Protected Health Information-** We will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

#### **USES OR DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT**

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

#### **USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED**

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

**Uses and disclosures required by law-** We may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

**Uses and disclosures for public health activities-** We may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

**Disclosures about victims of abuse, neglect or domestic violence-** We may disclose protected health information about an individual whom We reasonably believes to be a victim of abuse, neglect, or domestic violence.

# HIPAA Notice of Privacy Practices

**Uses and disclosures for health oversight activities-** We may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

**Disclosures for judicial and administrative proceedings-** We may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

**Disclosures for law enforcement purposes-** We may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

**Uses and disclosures about decedents-** We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

**Uses and disclosures for cadaveric organ, eye or tissue donation purposes-** We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Uses and disclosures for research purposes-** We may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

**Uses and disclosures to avert a serious threat to health or safety-** We may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Uses and disclosures for specialized government-** We may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

**Disclosures for workers' compensation-** We may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## **PATIENT RIGHTS UNDER HIPAA**

The following information describes your rights under the HIPAA Standards. We require that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**

**Right of an individual to request a restriction of uses and disclosures-** We will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section. Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.

**Confidential communication requirements-** We will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

**Access of individuals to protected health information-** An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

**Amendment of protected health information-** An individual has the right to ask to have We amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

**Accounting of disclosures of protected health information-** An individual has a right to receive an accounting of disclosures of protected health information made by us in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will be a reasonable cost-based fee for additional requests.

**Right of Breach Notification-** An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

## **COPY OF THIS NOTICE**

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

## **OUR DUTIES**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the notice currently in effect.

We are required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices will be available and posted at our office(s) and posted on our web site, if applicable.

## **COMPLAINTS**

If at any time you feel we have violated your HIPAA rights, please contact Clarity's Privacy Officer, 29 North Academy Street, Greenville, SC 29601 or (864) 331-1400, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323. We will not retaliate against any individual for filing a complaint.



\_\_\_\_\_ Date

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

Questionnaire Completed by: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**REFERRAL INFORMATION**

Primary Care Physician: \_\_\_\_\_

Referring provider (if different from primary care physician): \_\_\_\_\_

What are your reasons for seeking help for the child at this time?

When did you first become concerned about the child?

What are the most positive features about the child?

**FAMILY INFORMATION**

Name of Parent 1: \_\_\_\_\_ Name of Parent 2: \_\_\_\_\_

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

Highest Grade Completed: \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_

Who does the child live with (include siblings and ages)? \_\_\_\_\_

If any immediate family members (for example, parent, sibling, etc.) are living elsewhere, please list:

Age	Sex	Relationship to this Child	Frequency of contact
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Language(s) spoken/heard in the home: \_\_\_\_\_

Is the child adopted?  No  Yes

If yes, list date of adoption: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

## **PREGNANCY HISTORY**

Was the child's mother under doctor's care during the pregnancy?  No  Yes

During the pregnancy, did the mother take any medications or drugs (other than vitamins/iron), drink alcohol, or smoke cigarettes?  No  Yes

If yes, please describe: \_\_\_\_\_

Any complications during the pregnancy or delivery?  No  Yes

If yes, please describe: \_\_\_\_\_

Any specialized treatment provided to baby during and/or following delivery?  No  Yes

If yes, please describe: \_\_\_\_\_

Was the child born prematurely?  No  Yes If yes, what was the gestational age at delivery? \_\_\_\_\_ weeks

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Length of hospital stay following delivery: \_\_\_\_\_ Mother \_\_\_\_\_ Baby

Did any of the following occur during your baby's first month of life?

- Breathing Problems  Infection  Birth Defect  Excessive Vomiting  
 Jaundice (yellow)  Excessive Crying  Feeding Difficulty  Injury

## **DEVELOPMENTAL HISTORY**

Communication/Speech/Language: Seems/ed early Seems/ed on time Seems/ed late

If concerns, please describe: \_\_\_\_\_

Motor Skills: Seems/ed early Seems/ed on time Seems/ed late

If concerns, please describe: \_\_\_\_\_

Do you have concerns for the child's social development?  No  Yes

If yes, please describe: \_\_\_\_\_

Do you have concerns for the child's emotional development?  No  Yes

If yes, please describe: \_\_\_\_\_

Do you have concerns for the child's behavior?  No  Yes

If yes, please describe: \_\_\_\_\_

Do you have any additional concerns for the child's development?  No  Yes

If yes, please describe: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

## HEALTH HISTORY

Has the child had any of the following?

Convulsions, seizures, fainting spells?  No  Yes

If yes, please indicate when and describe: \_\_\_\_\_

Vision or eye problems?  No  Yes

If yes, when was the last time the child's vision has been screened or evaluated? \_\_\_\_\_

If yes, does the child wear glasses or contacts?  No  Yes (please specify) \_\_\_\_\_

Hearing problems?  No  Yes

If yes, when was the last time the child's hearing has been screened or evaluated? \_\_\_\_\_

If yes, does the child have hearing aid(s)?  No  Yes

Did the child pass their newborn hearing screening?  No  Yes

Recurrent ear infections?  No  Yes

If yes, please indicate when and describe: \_\_\_\_\_

Have PE tubes been inserted?  No  Yes

If yes, at what age(s) and how many times? \_\_\_\_\_

Allergies?  No  Yes

If yes, what is the child allergic to? \_\_\_\_\_

Any surgeries, serious illnesses, injuries (including head injuries), or accidents?  No  Yes

If yes, please indicate when and describe: \_\_\_\_\_

Has the child ever been hospitalized overnight?  No  Yes

If yes, when and why? \_\_\_\_\_

Has the child ever been given a diagnosis?  No  Yes

If yes, please indicate when and state diagnosis(es): \_\_\_\_\_

Please list any current health concerns: \_\_\_\_\_

Is the child taking any medications?  No  Yes

If yes, please list: \_\_\_\_\_

Does or has the child received any of the following services? If yes, please describe (when, how long, what for):

BabyNet / Early Intervention  No  Yes: \_\_\_\_\_

Speech/language therapy  No  Yes: \_\_\_\_\_

Occupational therapy  No  Yes: \_\_\_\_\_

Physical therapy  No  Yes: \_\_\_\_\_

Counseling  No  Yes: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

## EDUCATIONAL HISTORY

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_ School District: \_\_\_\_\_

What other schools has the child attended? (please list in chronological order beginning with nursery/preschool)

Are you worried about the child's school progress?  No  Yes

If yes, please describe: \_\_\_\_\_

Does the child receive extra help at school?  No  Yes

If yes, please mark any supports the child has received:

Tutoring  Small Group Intervention  504 Plan  Special Education (IEP)  Other  
(at school or privately) (such as, Rtl or LLI) \_\_\_\_\_

Has the child ever had any testing done by the school system or elsewhere?  No  Yes

If yes, please describe: \_\_\_\_\_

## FAMILY HISTORY

Is there a family history of the following? If yes, list who has/d these concerns

Learning Difficulties	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Reading	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Written Language	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Mathematics	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Attention Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Hyperactivity/Impulsivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Autism Spectrum Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Intellectual Disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Bipolar Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Schizophrenia/Delusions/Hallucinations	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Language/Speech Delay	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Any Genetic Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Conduct Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Drug/Alcohol Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Seizure Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Motor or Vocal Tics	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Hearing Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Visual Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Muscular Problems/Weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____
Other (please specify)	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____

**Additional Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle Month/Day/Year

Questionnaire Completed by: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### REFERRAL INFORMATION

Do you have concerns with how your child is using language (for example, greetings, naming objects, requesting)? If yes, please elaborate: \_\_\_\_\_  No  Yes

Does your child...	Always	Most of the time	Usually	Seldom	Never
Seem frustrated with his/her speech?					
Seem behind in speech and language development when compared to other children?					
Have a difficult time being understood by family members?					
Have a difficult time being understood by non-family members?					
Fear or avoid new speaking situations?					

### FEEDING HISTORY AND CURRENT FUNCTIONING

Does/did your child have difficulty with weight gain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does/did your child cough or choke while eating or drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are/were they more successful with specific food types?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If over 14 months, does your child still use a pacifier and/or bottle?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does/did your child have food preferences that interfered with mealtime?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### SOCIAL HISTORY AND CURRENT FUNCTIONING

Does your child respond to greetings from familiar people?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does your child initiate play with others?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does your child engage in pretend play by themselves?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever thought your child played with toys in an unusual manner?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does your child typically choose to play alone rather than with others?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### COMMUNICATION HISTORY AND CURRENT FUNCTIONING

If your child is not yet speaking in sentences, please estimate the number of words they use that other understand? [                    ]		
Are you concerned with how your child pronounces certain sounds/words?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you concerned your child does not understand language (object names, directions)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have concerns with how your child is using language (for example, greetings, naming objects, requesting)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

If you answered YES to any of the above questions, please elaborate below or on the back of this page:

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**PEDIATRIC  
FEEDING SUPPLEMENT:  
3 Day Diet History Form**

\_\_\_\_\_  
Date

**3 Day Diet Instructions**

Instructions: You are being asked to record ALL foods and drinks consumed by your child for 3 days in a row. The following directions will guide you in filling out the form. You need to complete this history and send the information to the Clarity Business Office with the rest of your forms, OR you will need to bring it with you to your appointment.

- Please fill out **all** the information at the top of the first page.
- Please record the **date and day** of the week for each day. Record **all food and drinks** consumed along with the **time** your child ate or drank. It is best to carry the history form with you and to record items immediately so that nothing is missed.
- Describe the food as accurately as possible by including a short explanation of the item and your best guess of the portion size.
- Record all beverages including water, coffee, tea, sports drinks, sodas, formula brand names (i.e. Enfamil, Prosobee, etc.), and any special recipes for drink mixtures your child uses (i.e. 24 calories Isomil + 1 tsp Polycose).
- Include any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- You may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/ drank better.
- Include any additional comments about your child's eating habits on this form (i.e. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

Example:

Date	Time	Food/Drink <small>Protein, Dairy, Vegetables, Fruit, Grains</small>	Amount	Bottle	Cup	Mouth	G-Tube
01/01/20	4:00PM	Gerber Applesauce	1 oz			x	
		White Bread (Wonder)	¼ slice			x	
		Ham lunch meat (Hormel)	½ oz			x	
		Mayonnaise	1 tsp			x	
		White grape juice	1 oz		x	x	
	6:30PM	Veggie Straws (Whole Foods 365)	5			x	
		Diced Pears (Del Monte)	1 plastic container			x	
	7:00PM	Similac Advance Formula	4 oz	x		x	
	9:00PM	Pediasure with Fiber	8 oz				x



