Midland
CHILDREN'S
rehabilitation center

802 Ventura Midland, TX 79705 PH: 432.498.2053 Fax: 432.682-4478 www.midlandchildrens.org

Dear Parent/caregiver,

Thank you for contacting us regarding therapy services for your child. Due to the demand for Physical, Occupation and Speech Therapy in our area, we are currently managing a wait list for all three services and are revising our intake process in order to better serve the community. The first step is to completely fill out the attached paperwork to the best of your ability and return it to our facility *with a prescription for therapy from your physician*. The prescription must be discipline specific, preferably stating "evaluation and treatment".

Once the paperwork is received and determined to be complete, you will be placed on a waiting list for services. As appointments become available, we will call you to schedule an evaluation. Please be sure to contact us if any information has changed. If we are unable to reach you, your child will be removed from the waiting list and will not receive an evaluation from Midland Children's Rehabilitation Center. In the event that you are seeking services for multiple disciplines, you will be scheduled for separate evaluations at different times.

Evaluations typically take one hour and once the evaluation is complete, our therapists will determine if your child needs therapy services. We will contact you as soon as possible following the evaluation to set up your child's therapy schedule. Our hours of operation are Monday through Thursday from 8 am to 5:30 pm, and Friday from 8 am to 12 pm. There is no guarantee as to the availability of any specific appointment time.

The following items must be received before your child can be added to the waiting list:

- Contact Information/Demographics
- Consent Forms
- Speech Intake forms (if requesting speech therapy)
- Prescription for specific therapy discipline (OT, PT, ST) **"evaluation and treatment"**

Due to the nature of our waiting list, all paperwork listed above must be turned in at the same time. The front office will not accept any incomplete paperwork.

Please feel free to contact us at any time if you have questions. We look forward to meeting you and your child soon at the time of their evaluation.

Sincerely,

Candelaria Bejarano
Therapy Secretary and Scheduler

Midland CHILDREN'S rehabilitation center

Contact Information

Date Completed: ______________________

Name of person completing Case History Form: ____

Relationship to child: ____

Language(s) spoken in the home: ____

Language:

____English understood

____Interpreter needed

Services Requested: ____ Occupational Therapy

____ Physical Therapy

____ Speech Therapy

IDENTIFYING INFORMATION/ FAMILY HISTORY:

Child's Name: Last: ________________________ First: ______________________ MI: ____

Date of Birth: _______________ Age: _______ Gender: ____Male _____Female

Street Address: _______________________________________

City:________________________________State: _____________ Zip: ____________

Primary Diagnosis: ____

Mother/Guardian's Name: ____ Age: ______

Address: ____

E-mail: ____

Cell #:__________________________________ Home#: __________________________________

Education: _________________________________ Occupation: __________________________

Employer: _________________________________ Work Phone #: _______________________

Work Address: ____

Father/Guardian's Name: ____ Age: ______

Address: ____

E-mail: ____

Cell #:__________________________________ Home#: __________________________________

Education: _________________________________ Occupation: __________________________

Employer: _________________________________ Work Phone #: _______________________

Work Address: ____

Emergency Contact (other than parent or guardian):

Name: _____________________ Phone number:_____________________ Relationship:_________________

Midland CHILDREN'S rehabilitation center

Demographics

The following information is required. Please answer **ALL** questions. MCRC offers services at no charge to our clients. However, we do have to seek funding from various sources including grants, foundations, and private donors. MCRC needs this information to present a clear picture of the population we serve.

What type of insurance do you currently have?

- ☐ No insurance
- ☐ Medicaid
- ☐ Private Insurance: ___________________
- ☐ SSI/Disability

What is your Annual income?

- ☐ Less than $10,000
- ☐ $10,001-$20,000
- ☐ $20,001-$30,000
- ☐ $30,001-$40,000
- ☐ $40,001-$50,000
- ☐ $50,001-$60,000
- ☐ $60,001-$70,000
- ☐ $70,001-$80,000
- ☐ $80,001-$90,000
- ☐ $90,001-$100,000
- ☐ $100,001 & Over

How many people are in your household? ______

What is the reason you are seeking services at MCRC? (check all that apply)

- ☐ Insurance ran out
- ☐ No longer qualify for Medicaid
- ☐ Do not have private insurance
- ☐ Medicaid is primary insurance
- ☐ Have insurance or other coverage, but prefer to come to MCRC
- ☐ It is the only facility that has the program we need
- ☐ Other____________________

Please list your child's diagnoses:

____

____

____

What is your ethnicity?

- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Caucasian (Non-Hispanic)
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ Others: ___________________

How did you hear about MCRC?

- ☐ Physician
- ☐ Hospital
- ☐ TV
- ☐ Internet
- ☐ Newspaper
- ☐ Employer
- ☐ Facebook
- ☐ Self
- ☐ Friend ______________
- ☐ Other ______________

If you had to pay for therapy services, what is the approximate cost that your family would incur?

- ☐ $20 Copay per visit
- ☐ $50 Copay per visit
- ☐ $___ Out-of-pocket per visit

What is the maximum number of visits your insurance would allow?

- ☐ 10-20 visits a year
- ☐ 21-30 visits a year
- ☐ 30+ visits a year
- ☐ Unknown

Midland CHILDREN'S rehabilitation center

Brothers and Sisters: (living at home)

Name:____ Age:____________________

Name:____ Age:____________________

Name:____ Age:____________________

Name:____ Age:____________________

Others living in your home:

Name:____ Relationship:______________

Name:____ Relationship:______________

Educational Information:

Child's school: _____________________________________ Phone: ______________________________

Grade: __________ Teacher's Name: ____

Does your child receive special education services, PT/OT/ST? If so, please include length of time per day:

____

Does your child attend daycare? ____yes ___no If yes, how many hours a day?_____________________

Any customs, religious beliefs, or wishes that might affect care?__________________________________

Has your child received therapy services in the past?

Type (PT/OT/ST): ________________________ **Where:** ______________________________

Duration: ________________________________

Goals Addressed:____

Type (PT/OT/ST): ________________________ **Where:** ______________________________

Duration: ________________________________

Goals Addressed:____

Is your child currently receiving therapy services at another facility?

Type (PT/OT/ST): ________________________ **Where:** ______________________________

Goals Addressed:____

Midland CHILDREN'S rehabilitation center

MEDICAL/ DEVELOPMENTAL INFORMATION:

Child's Family Physician: ____

Address: ____

Phone: _____________________ Date child was last seen by this physician_____________________

Is child seeing a specialist? ____ Orthopedist Name: _________________________ City______________

_____Neurologist Name: _________________________ City______________

other: _________________ Name: _________________________ City______________

Please check if your child is being followed by a doctor(s) at:

________Cook Children's Hospital, Ft. Worth ________Shriner's Hospital, Houston

________ Scottish Rite Hospital, Dallas _________________________________ other

Please describe your child's birth story. List any complications during pregnancy, birth, or infancy:

____

____

Birth Weight: _______ pounds _______ ounces **APGAR scores:** ______________________________

Was your child premature? ____yes ____no if yes, he/she was born at _____________weeks.

Was your child in NICU? _____yes ____no If yes, how long?___________________________________

If yes, please list the reason____

____

Please list any childhood illnesses and/ or medical conditions (past and present):

____

____

Name of current medication Amount and how often Reason

____

____

____

Midland CHILDREN'S rehabilitation center

Medication Allergies: ___yes ___no if yes, please list ____

Food Allergies: ___yes ___no If yes, please list____

Medical Safety Precautions that we need to be made aware of while evaluating/treating your child:

____

Please rate your child's general health:

_____excellent ______good _______fair _______poor

Has your child had any surgeries or hospitalizations? ____yes ___no

Type of surgery Year Reason Physician City

____

____

____

Does your child suffer from chronic ear infections? Please describe frequency and treatment:

____

Has your child had a formal eye examination? Please describe: ________________________________

Has your child had a hearing test? Has your child had tubes in his/her ears, hearing aids, or cochlear implants? Please describe:

____

Developmental Milestones:

Speech Skills	Age:	Motor Skills	Age:
Babbling		Rolling	
First Word		Sitting unassisted	
2 word utterance		Crawling	
Phrases/sentences		Walking	
Chewing solid foods		Drinking from cup	
Reaching		Spoon Feeding self	

Midland CHILDREN'S rehabilitation center

Equipment:

Does your child currently use any adaptive assistive equipment? ___yes ____no If yes, please check those applicable: ______braces _____crutches _______walker______manual wheelchair ____power wheelchair ______hand splints ____other: (list)____

If your child uses a wheelchair, how old is equipment? _______less than one year ______1-3 years _______4-5 years ________more than 5 years

Does your child need equipment that he/she does not presently have or has outgrown? ___yes ___no _____braces ________walker _____crutches_____manual wheelchair _______power wheelchair _______hand splints_______ bath chair ________________________________other

Sensory Issues:

My child seems overly sensitive to lights/sounds. ______yes ______no

My child seems overly sensitive to touch/movement. _______yes ______no

My child will only eat certain types of foods ______yes _____no

If yes, list the types____

UNDERSTANDING LANGUAGE? COMMUNICATING:

Does your child react or respond to sounds? When you talk to your child, how much does he/she understand (a few words, phrases, directions)**?** Please describe: _________________________________

____

SOCIAL BEHAVIOR:

Please describe any social concerns (short attention span, interaction with children and adults, overly active, aggressive behaviors): ____

____

FEEDING/ SWALLOWING:

Please describe any feeding and/or swallowing concerns (difficulty biting/ chewing, accepting new foods/ textures): ____

____

Midland CHILDREN'S rehabilitation center

CHILD OBSERVATIONS:

Please describe how your child ascends/ descends stairs: ____

____

Has your child established a hand preference? Right ______ Left ______

Please describe how much help, if any, your child requires for self-care skills (dressing, bathing, feeding, etc.) ____

____

Describe your child's balance skills and motor coordination: _____________________________________

____

Please list any activities that your child particularly enjoys or does well and anything that may be useful as rewards:

____

____

Additional Information:

What is it about your child that concerns you?____

____

____

____

Do you have specific goals for your child in the next 12 months that could be helped with therapy? (Please be more specific than "to get better")

PT:____

OT: ____

Speech:____

CONSENT TO TREAT

The State of Texas
County of Midland

WHEREAS, the undersigned are the parent/guardian of

(Child's Name) ____DOB ________________and,

WHEREAS, WE desire that said child shall receive treatment without charge to us or the child at the Midland Children's Rehabilitation Center in Midland, Texas: and, we wish to waive and release any and all claims arising in our favor or in favor of said child in connection with said matter.

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS: That we hereby request said Midland Children's Rehabilitation Center to furnish treatment for our child. In case of any character of injury or damage to said child growing out of or in said Center, whether the same should occur at the Center or en route to or from the same, we the undersigned, hereby waive and release any and all claim or claims which we or said child may now or hereafter have against any person in anywise connected with said Center or in any way acting for it as a part of its treatment program or in consideration of the treatment therefore given, or to be hereafter given, to said child.

I hereby authorize the above named individual for participation in the following activities if their evaluation indicated the need for this service: medical clinics, wheelchair clinics, orthotic clinics, splinting and casting applications, occupational, speech and/or physical therapy intervention, aquatic therapy, equine assisted therapy and Midland Children's Rehabilitation Center sponsored activities.

Parent/Guardian:___________________________________ Date:_________________

Witness:____ Date:_________________

______ (Initial) Although general referrals to physicians and/or vendors are provided as a courtesy to our clients, MCRC does not endorse any physician or vendor over another. MCRC does not make any representations and cannot be held responsible for any interactions or treatments mutually agreed upon between you and the physician or vendor you choose.

Midland
CHILDREN'S
rehabilitation center

Authorization to Disclose Therapy Records

As parent and/or legal guardian of ____ DOB: ____________________

I specifically authorize the release of information specified below **only** to the individual(s) listed on this form.

☐ Complete Copy of All Records

☐ Telephone/verbal communication

☐ Counseling & Consultation Visits

☐ Condition and Dates of Visits

☐ Other, please specify: ____

Please list names and information of individuals, including yourself and your spouse, who have your permission to your child's medical records and information.

1. Name: ____ Relationship to Child: ________________

Address: ______________________________________ Phone number: ____________________________________

2. Name: ____ Relationship to Child: _________________

Address: ______________________________________ Phone number: ____________________________________

3. Name: ____ Relationship to Child: _________________

Address: ______________________________________ Phone number: ____________________________________

4. Name: ____ Relationship to Child: _________________

Address: ______________________________________ Phone number: ____________________________________

☐ I understand that I have the right to revoke this authorization, but I must do so in writing and it will not apply to information previously released by the authority of this document.
☐ I also understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws.
☐ I understand authorizing the disclosure of the information identified above is voluntary.

____ Date: ______________________________
Signature of Parent/Legal Guardian

____ Date: ______________________________
Signature of Witness

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Client Name: ____ DOB: _______________________________

Address: __________________________________ City: ________________ State: ______ Zip: ______________

We are requesting that you authorize the agencies or persons named below to disclose to each other confidential information regarding the above named client.

____ AND ____

Name and Position of MCRC Staff — Person/Agency

Midland Children's Rehabilitation Center — ____

Name of Person/Agency

Address: 802 Ventura — ____

Midland, Texas 79705 — ____

Phone: (432) 498-2053 — ____

Fax: (432) 682-4478 — ____

Records to be released/disclosed: ☐ Evaluation report ☐ Treatment Records ☐ Medical Records

Purpose of release/disclosure:

☐ To provide information pertinent to client's therapy and/or medical treatment.

☐ Other: ____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 45 CFR §164.508(c)(I)(iii).
I understand that treatment or payment cannot be conditioned on my signing this Authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance upon the Authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law. 45 CFR §164.508(c)(2)(I); 45 CFR §164.508(c)(2)(ii):
This Authorization will expire One Hundred and Eighty (180) days from the date of my signature below, unless I revoke the Authorization prior to that time or unless specified by date, event, or condition as follows:
___________________________________. 45 CFR § 164.508(c)(1)(v)

Date of Signature:___________________ Signature:____

Patient or legally authorized representative 45 CFR §164.508()(1)(vi)
Printed Name: ____
Relationship to Patient 45 CFR §164.508(c)(1)(iv):_______________
Address:____
Telephone:____

Attendance Policy/Prescription Requirement

Welcome to Midland Children's Rehabilitation Center. We are pleased that your child will be receiving services here at the center.

Midland Children's Rehabilitation Center is a 501(c)(3) non-profit organization supported by the generosity of the citizens of Midland and Texas. The vision of the board of directors is that children with disabilities should receive basic therapy services at *no charge to the children or their families.* For this reason we have an extensive waiting list of children requiring our services. Therefore, **please review the following adopted policy:**

1. **If your child has three "No Call/No Show" (NCNS) appointments, they will be discharged from therapy and their slot will be given to the next child on the waiting list**. We know that some children have health and medical issues that may interfere with a regular therapy schedule. A non-traditional therapy schedule may be considered for those with severe health and medical issues which may consist of home exercise programs, less frequent therapy sessions (i.e. once a month), etc. Visit with your therapist about your child's particular scheduling needs and how you will deal with them, together. Please communicate with your therapist about a best plan for your child.

   MCRC's Attendance Policy is as follows:
   Each child is required to have an overall attendance rate of 85% for all treatment sessions per discipline seen. If a child has three NCNS's or does not meet the 85% attendance rate, the therapy slot will be given to the next child on the waiting list and they will be discharged from therapy services.

2. **Prescription Requirement: I understand that my child cannot receive therapy services unless there is a current written prescription from my child's primary care physician on file with MCRC. (The prescription for therapy must be dated within the past 12 months and list the specific therapy service my child is to receive.)**

3. **MCRC will not provide services to children who are currently receiving the same services (PT, OT or speech) with any other facility.** If your child is receiving services anywhere else, other than at school, please discuss with your therapist.

____ Date:______________________
Parent Signature

Family Responsibility Agreement

Patient's Name: ______________________________________ **Birthday: _________________**

Welcome to Midland Children's Rehabilitation Center (MCRC). To make the most out of the services at MCRC, it is important that you understand what we expect of our patients and their families.

Therapist Responsibilities:

1. Our goal is to provide each patient with the skills to function at their very best at home, in school and out in the community.
2. We will create a treatment plan specific to your child and his / her needs based on test results, identified strengths, identified weaknesses and goals set by the child's family.
3. We will provide open communication with the family regarding home program recommendations, suggested community services and other professionals that your child might need to see.

Family Responsibilities:

1. Before being seen for therapy, MCRC **MUST** have a current prescription for the specific type of therapy that is recommended.
2. Be on time to each appointment and evaluation
   a. If more than 15 minutes late to an appointment, the session will be considered a "No Call/No Show".
   b. If you are more than 15 minutes late, the therapist will not see your child for their appointment
3. The primary caregiver must be present for all OT, PT and ST evaluation(s).
4. Each patient should be dressed appropriately for the specific therapy they will be receiving.
5. Parents or guardians should stay at the clinic during treatment sessions in case of emergency. This will also allow the therapist to discuss the treatment session with you and recommend things to do at home.
6. No cell phone use in treatment areas.
7. Share any changes in information (medical, phone number, address, etc.) with the front office staff.
8. For the best outcome, follow through with home recommendations made by the therapist.
9. To protect privacy, no photography or videos are allowed without proper approval (includes cell phone, cameras, or video cameras)
10. Complete all mandatory MCRC paperwork

Attendance:

1. If you need to cancel your appointment or are going to be late, please call the office at (432)498-2053 as soon as possible.
2. Please call to cancel your child's appointment if they have had vomiting, diarrhea, fever or any contagious illness within the 24 hours prior to their therapy appointment.

Reasons for Discharge:

1. All goals set by the therapist at the initial evaluation are met and therapy is no longer recommended.
2. A plateau has been reached regarding progress toward therapy goals.
3. Your child misses 3 therapy sessions without calling to cancel (This is considered a "No Call/No Show" for appointment).
4. Your child does not maintain an attendance rate of 85% for all treatment sessions.
5. The child's behavior prevents their ability to participate and make progress during therapy.
6. Child is receiving services (PT, OT, ST) at another facility - MCRC does not duplicate services.

I have read this agreement and understand my responsibilities and why they are important.

________________________	____________	________________________	____________
Parent / Legal Guardian's Signature	Date	Therapist's Signature	Date

Midland
CHILDREN'S
rehabilitation center

Patient's Name: ____________________ **DOB**: _______________________

Parent Informed Consent for Student Therapists

Midland Children's Rehabilitation Center provides learning experiences for many students who are studying to become future physical, occupational, and speech therapists. We are proud to be considered a teaching facility and frequently have students who have come to MCRC for their pediatric rotation. While here at MCRC, each student therapist may have the opportunity to follow your child's therapist to observe various treatment sessions, to plan their own treatments for your child and eventually to lead the therapy session on their own with the supervising therapist nearby for assistance if needed.

Each child's care is our top priority. Your child will receive the same quality therapy and care with a student therapist as they would with their regular therapist. Therapists spend plenty of time supervising, training, and discussing your child's diagnosis and plan of care thoroughly. Your child's therapist will evaluate any possible safety concerns before the student therapist is allowed to work with your child by themselves.

It is of great benefit for your child to be seen by a student therapist. The student therapist will come with the latest research and will have a fresh set of eyes to try new therapy activities with your child. It will also benefit the patient to listen to and adjust to another adult.

— —

I understand that my child will at some point receive therapy services which will be provided by a student therapist at Midland Children's Rehabilitation Center. I understand that my child's therapist will be closely supervising the students; however, may not always be in the room during therapy sessions.

________________________________ ______________________
(Parent/guardian's printed name) (Date)

________________________________ (Parent/guardian's signature)

Publicity Release for MCRC

Child's Name______________________ Date _________________

_____ I **do not** want my child's photograph to be used in any publicity by the Center.

____ I give my permission to the staff of Midland Children's Rehabilitation Center to utilize facts related to diagnosis and/or for my child to be photographed by the staff of MCRC, Newspaper Photographers and TV reporters for the purpose of: Staff training, fundraising and publicity materials to include but not limited to brochures, slideshows, newsletters, MCRC website, social media, TV and newspaper ads.

Please list any exceptions to the above items where you do not want your child's picture to be included.

____

____

This publicity release is granted from the above date and may be revoked or changed by the parent/guardian at any time by submitting a written request to Midland Children's Rehabilitation Center.

I have read and understand this document.

_______________________ _______________________
Parent or Guardian Signature Parent or Guardian Name (Please Print)

Midland CHILDREN'S rehabilitation center

SPEECH AND LANGUAGE CASE HISTORY FORM

This form is to be filled out and returned to the center before an evaluation is scheduled.

Date ___________________________
Name of child ____
Date of birth ____________________________ Age ____________
Name of person completing this form ___________________________
Relationship to child ____

FAMILY HISTORY

Siblings: ___________________________________ Age: ________
___________________________________ ________
___________________________________ ________
___________________________________ ________

Is there a family history of: Yes/No

- Speech/Language Difficulties ________
- Hearing Impairment/Deafness ________
- Learning Difficulties ________
- Developmental Difficulties ________

If you responded "yes" to any of the above, please describe:

____
____
____
____

MEDICAL HISTORY

Please indicate if your child has experienced any of the following conditions:

Allergies	Yes ____	Explain ____
Autism	Yes ____	Explain ____
Attention Deficit Disorder	Yes ____	Explain ____
Asthma	Yes ____	Explain ____
Epilepsy	Yes ____	Explain ____
Seizures	Yes ____	Explain ____
High Fevers	Yes ____	Explain ____
Meningitis	Yes ____	Explain ____
Muscular Disease	Yes ____	Explain ____
Pneumonia	Yes ____	Explain ____

Midland CHILDREN'S rehabilitation center

Traumatic Brain Injury Yes ____ Explain ____
Tonsillitis Yes ____ Explain ____
Enlarged Adenoids Yes ____ Explain ____
Hearing Loss Yes ____ Explain ____
Swallowing Dysfunction Yes ____ Explain ____
Other ____

List any medications prescribed for your child ____
____

Has your child had an audiological evaluation (hearing test)? Yes ____ No ____ Were the results normal? If no, please explain____
____
____

STATEMENT OF THE PROBLEM

Describe in your own words what problem your child is having with speech, language, and/or hearing:
____
____
____
Please list any other concerns you have regarding your child's development:
____
____
____
Is your child aware of, or frustrated by, any speech/language difficulties? Yes _____ No _____
Does your child have a formal diagnosis? Yes_____ No______ If yes, what? ____________________________

SPEECH & LANGUAGE SKILLS
Please answer "yes" or "no" or "sometimes" to the following questions:

Does your child respond to his/her name? Yes _____ No _____ Sometimes _____
Will your child get common objects when asked? Yes _____ No _____ Sometimes _____
Does your child follow simple directions? Yes _____ No _____ Sometimes _____
Will your child point to pictures as you name them? Yes _____ No _____ Sometimes _____
Does your child label pictures? Yes _____ No _____ Sometimes _____
Does your child ask questions? Yes _____ No _____ Sometimes _____ (Examples ________________________
____)
Does your child identify and/or label actions? Yes _____ No _____ Sometimes _____
Does your child answer yes/no questions? Yes _____ No _____ Sometimes _____
Does your child answer "WH" (who, what, where, etc.) questions? Yes _____ No _____ Sometimes _____
Does your child repeat or "echo" others' expressions? Yes _____ No _____ Sometimes _____
Does your child repeat questions or part of questions rather than answering them? Yes _____ No _____ Sometimes _____

Midland CHILDREN'S rehabilitation center

Does your child **excessively** recite/repeat words from video tapes/DVDs, songs, or television programs?
Yes _____ No _____ Sometimes _____

Has your child said a word a few times, and then never used it again? Yes _____ No _____ Sometimes _____ If "yes", when? __________________________ What words? ____
Did language development seem to just stop? Yes _____ No _____ Sometimes _____ If "yes", when? _______
____
How does your child indicate his/her needs/wants to you? ____
____
How does your child indicate he/she does **not** want something or does not want to do something? ___________
____
____
What types of words/sentences does your child express independently? _________________________________
____
____
Is your child's speech difficult to understand? Yes _____ No _____ Sometimes _____
What types of speech errors does he/she exhibit? ____
____
____
Does your child get "stuck" when attempting to say a word? Yes _____ No _____ Sometimes _____
Do you have concerns about your child's voice? Yes _____ No _____

ORAL MOTOR & FEEDING HISTORY

Has your child experienced feeding/eating difficulties (biting, swallowing, chewing)? Yes _____ No _____
If "yes", explain ____
____
Does your child eat by themselves using utensils? Yes _____ No _____ Sometimes _____ Drool? __________

Does your child put toys in mouth? Yes _____ No _____ Sometimes _____ If "yes", explain _______________
____
Does your child have food preferences/aversions? Yes _____ No _____ Sometimes _____
If "yes", explain____

BEHAVIORAL INFORMATION

INFANCY
Was a silent infant? Yes _____ No _____ Sometimes _____
Was an inconsolable infant? Yes _____ No _____ Sometimes _____
Very happy infant (rarely cried, did not desire interaction /affection) Yes _____ No _____ Sometimes _____
Other comments____

PLAY
Prefers to play alone? Yes _____ No _____ Sometimes _____
Plays poorly with other children or does not interact with others? Yes _____ No _____ Sometimes _____
Frequently lines items in a row? Yes _____ No _____ Sometimes _____

Protests if line is interrupted? Yes _____ No _____ Sometimes _____
Holds (clutches) items for extended periods of time? Yes _____ No _____ Sometimes _____

Frequently counts (objects, items, actions, etc.) Yes _____ No _____ Sometimes _____
Has unusual interest (strips of paper, electrical cords, etc.) Yes _____ No _____ Sometimes _____
Spins objects? Yes _____ No _____ Sometimes _____
What is the average length of time your child can stay playing at one activity? ___________________________
Other comments
____
____

CONDUCT
Is difficult to manage? Yes _____ No _____ Sometimes _____
Has a behavior problem? Yes _____ No _____ Sometimes _____
Displays temper tantrums? Yes _____ No _____ Sometimes _____
Consistently has a catastrophic reaction with told "no"? Yes _____ No _____ Sometimes _____
Discipline is ineffective? Yes _____ No _____ Sometimes _____
Is overly active? Yes _____ No _____ Sometimes _____
Has a short attention span? Yes _____ No _____ Sometimes _____
Is aggressive towards self? Yes _____ No _____ Sometimes _____
Is aggressive towards other? Yes _____ No _____ Sometimes _____
Is destructive with objects? Yes _____ No _____ Sometimes _____
Other comments
____
____

GENERAL
Is withdrawn? Yes _____ No _____ Sometimes _____
Rocks back and forth? Yes _____ No _____ Sometimes _____
Acts as if deaf? Yes _____ No _____ Sometimes _____
Covers ears with hands? Yes _____ No _____ Sometimes _____
Has limited eye contact? Yes _____ No _____ Sometimes _____
Has difficulty with change/transitions? Yes _____ No _____ Sometimes _____
Other comments
____
____

Midland CHILDREN'S rehabilitation center

FEEDING HISTORY

Date ___________________________
Name of child ____
Date of birth ____________________________ Age ____________
Name of person completing this form ___________________________
Relationship to child ____

Please answer the following questions regarding your child's feeding skills:

In infancy, child was ______________________________(breast fed, bottle fed, tube fed). If tube fed, why and for how long? ____
____
____
Was he/she on a ventilator? Yes _____ No ______ If yes, how long? ___________________________________
How long did early feedings last? ____
Were any strategies (i.e., positioning, external jaw/cheek support, different bottles, nipples, etc.) used to help with early feeding? If yes, explain. ____
____
____

If your child is fed orally:

When did he/she transition from formula/breast milk/Pediasure, etc. to baby foods (pureed)? _______________
____
When did he/she transition to textured foods? ____
When did he/she transition to soft solids? ____
When did he/she transition to solid foods? ____
What is his/her current diet? (Please provide amounts and types of a typical day's intake- both orally and by tube)
____
____
____
____
____
____
____
____
____
____
____

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Check the following descriptions of behaviors/actions that are consistently exhibited (at least once per week) at the mealtime:

______a poor appetite
______disinterest in food
______food refusal
______extreme food "pickiness"
______talks with mouth full
______gagging with or without vomiting
______mealtime tantrums
______unusual food habits
______food-texture selectivity
______excessive overreacting
______yells
______whining or fussing at mealtimes
______requests for non-served foods
______takes food from another's tray/plate
______gets out of seat
______easily distracted from eating
______throws food
______"messy" eating; frequent spills
______chews with mouth open
______has ability, but doesn't use napkin
______prefers liquid over solid food
______poor eye contact with communication partner or feeder
______doesn't keep hands to self
______eats too fast
______eats too slow
______doesn't orient to feeder, but orients at other times
______expelling of food
______takes bites that are too large
______exhibits self-stimulatory behavior at mealtime
______talks too much at mealtime
______takes bites that are too small
______drinks too fast
______ignores communication partner/ feeder

Check the following reactions that have been observed with eating:

- ☐ Coughing — How often per week, month, etc.? ________
- ☐ Gagging — How often per week, month, etc.? ________
- ☐ Slow eating — How often per week, month, etc.? ________
- ☐ Choking — How often per week, month, etc.? ________
- ☐ Wet vocal quality — How often per week, month, etc.? ________
- ☐ Noisy breathing associated with feeding
  How often per week, month, etc.? ________
- ☐ Upper respiratory infections, pneumias, etc.
  How often per week, month, etc.? ________
- ☐ Other physical signs associated with eating (i.e., heart rate, color changes, respiratory changes, weight loss, etc.)
  Describe what has been observed and how often it has occurred in the past year: ____________________
  ____
  ____
- ☐ Hospitalizations in the past year?
  Why? ____
  How long? ____

What is your child's current weight and height? ____

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Feeding Preferences and Current Practices

What is your child's preferred temperature for liquids? ______________________
- For foods traditionally served warm? ______________________
- For foods traditionally served cold? ______________________

Does your child prefer foods:
- With strong tastes? ______________________
- With bland tastes? ______________________
- Both? ______________________

Please list 4-5 of your child's favorite foods: ____
____
____

Please list 4-5 foods your child doesn't like: ____
____
____

Is your child's food modified for him/her (i.e., chopped, ground, pureed, etc.) If so, please explain: ___________
____
____

Does your child receive any vitamin/mineral supplements? If so, please explain: __________________________
____
____

Does your child use any particular bowls, utensils, cups, etc.? If so, please describe: _______________________
____
____

Does your child sit in a special chair for meals? Yes _____ No _____ If yes, please explain: _______________
____
____

Does your child need "help" with self-feeding? Yes _____ No _____
- With utensils? Yes _____ No _____
- With fingers? Yes _____ No _____

Does your child feed himself/herself? Yes _____ No _____
Is your child fed by others nearly 100% of the time? Yes _____ No _____

What are your goals for your child related to feeding/swallowing?
____
____
____
____

What are your primary concerns for your child related to feeding/swallowing?
____
____
____
____

Midland CHILDREN'S rehabilitation center

FLUENCY QUESTIONAIRE

When was stuttering first noticed?
____

Who first noticed the child's stuttering?
____

Was the onset sudden (over one-seven days) or gradual (two weeks or more)?
____

In your opinion, what was the most important cause of the stuttering?
____

Indicate whether or not the following behaviors or characteristics are observed when your child is stuttering:

Behavior	**Never**	**Sometimes**	**Frequently**
Repeating sound/syllable (ba-ba-baby)	1	2	3
Repeating short words (and-and)	1	2	3
Repeating phrases or longer words	1	2	3
Prolonging vowels (aaa)	1	2	3
Prolonging consonants (sss, mmm)	1	2	3
Silent blocks (b-aby)	1	2	3
Abandoned words (ba-)	1	2	3
Revisions (I want) I need to go	1	2	3
Interjecting (ah, um)	1	2	3
Other____________________	1	2	3

Have you observed any of the following behaviors or characteristics in your child's current speech?

Behavior	**Never**	**Sometimes**	**Frequently**
Facial Grimaces	1	2	3
Eye closing/blink	1	2	3
Eyes wide open	1	2	3
Tense lips	1	2	3
Tense tongue	1	2	3
Wide-opened mouth	1	2	3
Tension in jaw	1	2	3
Tremor in lips, jaw	1	2	3
Tension in throat	1	2	3
Respiratory irregularities	1	2	3
Upward swings in vocal pitch	1	2	3
Tilt head	1	2	3

Midland CHILDREN'S rehabilitation center

Behavior	Never	Sometimes	Frequently
Tense movement of arms/legs	1	2	3
Loss of eye contact with listener	1	2	3
Giving up on talking	1	2	3
Comments about speech difficulty	1	2	3

What did you do when you first noticed your child's stuttering?

____

How has your child's fluency changed since its onset?

____

Is your child stuttering primarily on the first words of sentences or on words throughout the sentence?

____

Do you feel your child is aware of stuttering? If yes, please explain.

____

Describe situations in which your child's stuttering is worse:

____

____

Is there a history is stuttering in the family? If yes, please explain.

____

What would your goals be if your child was enrolled in therapy for stuttering?

____

____

Midland CHILDREN'S rehabilitation center

MCRC Policies to Remember:

In case of **FOUL WEATHER:**

- MCRC will follow the guidelines recommended by MISD for center closure or delayed opening.
- A message will be placed on the Center answering machine explaining alternate hours of operation for the day based on the recommendation per MISD.

Regarding **PAYMENT**:

- There is no charge for the evaluation or therapy your child may receive at MCRC. We do NOT bill insurance. We DO NOT receive any state or federal funding.
- We are funded 100% through private donations, special events, corporate support and grants.
- Your support is needed! A monthly donation is one of the easiest ways to support MCRC. Please visit www.MidlandChildrens.org/donate to make a difference today.

In case of **CHILD ILLNESS:**

- Your child must be free of vomiting and diarrhea 24 hours **prior to their appointment.**
- Your child must be fever free for 24 hours **prior to their appointment** without the assistance of fever reducing medication.
- Parents should use their best judgement regarding their child's ability to tolerate treatment sessions & the safety/well-being of other clients.
- Parents are responsible for calling and notifying MCRC of cancellation prior to your appointment time.

Regarding **PRIVACY:**

- No personal photographs or videos are permitted during your visit to MCRC
- If you wish to capture your child through video or pictures, please speak with your therapist
- Parents must be invited to attend a therapy session. To protect the privacy of other clients, roaming the facility without authorization is not allowed.

Regarding **ATTENDANCE:**

- Consistent attendance is crucial for therapeutic benefit
- If you are more than 15 minutes late to an appointment, the session will be considered a "No Call/No Show" AND your child will not be seen for their appointment.
- The client must meet overall attendance of 85%
- If a client misses 3 sessions without calling the Center for notification ("No Call/No Show") it is an automatic discharge from therapy services.
- 3 consecutive weeks are permitted for client vacation. Time periods longer than 3 consecutive weeks are subject to risk of losing your treatment spot

Regarding **PRESCRIPTION REQUIREMENT:**

- Therapy services cannot be received unless a current written prescription from the primary physician is on file with MCRC.
- The prescription must be dated within the past 12 months and list the specific therapy disciplines (OT, PT, ST) to be received.