SANDCASTLE
CLINICAL & EDUCATIONAL SERVICES
LA HEARING CENTER

THERAPY PERMISSION FORM

Client name: _____ Date of birth: _____

Please read and initial each item. Thank you.

_____ I give permission for Sandcastle to enroll my child in a therapy program.

_____ I understand that I must notify Sandcastle prior to the appointment time if my child is unable to attend a scheduled therapy session.

_____ I understand that under special circumstances make up sessions may be arranged for missed therapy sessions. However, this arrangement is not always possible due to scheduling commitments.

_____ I am aware that observations or participation in therapy session is supported and encouraged.

_____ I give permission for individuals involved in my child's program to observe my child's therapy session.

_____ I give permission for my child to be seen by an alternate provider in the event that the regular treating provider is absent.

_____ I understand that if my child has excessive absences I will be notified about the discharge of my child from therapy.

_____ _____

Signature of Parent or Guardian Date

SANDCASTLE
CLINICAL & EDUCATIONAL SERVICES
LA HEARING CENTER

PEDIATRIC CASE HISTORY

CLIENT NAME: _____ DATE OF BIRTH: _____
First Name *Middle Initial* *Last Name*

Reason for Referral:_____Problem First Noted:_____

PREGNANCY AND BIRTH HISTORY:

Biological mom's date of birth: _____If unknown, check here: ☐

Name of birth hospital: _____ If unknown, check here: ☐

Was (s) he premature? ☐ Yes ☐ No How many months was the mother pregnant with this child? _____

Birth weight: _____ How long did labor last? _____

APGAR Scores: _____ Was (s) he admitted to the NICU? ☐ Yes ☐ No If yes, for how long?_____

Were there any abnormalities noted at birth? ☐ Yes ☐ No Describe: _____

Were there any complications with pregnancy, delivery or birth? ☐ Yes ☐ No If yes, please describe: _____

_____

Were there any medications, drugs or alcohol consumed during pregnancy? If so, please describe: _____

_____

To your knowledge, has (s)he ever been exposed to ototoxic medication? ☐ Yes ☐ No

Did your child pass the newborn hearing screening? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY:

Milestone:	Age:	Milestone:	Age:
Head held up		Walked alone	
Sit unsupported		Reacted to noises, sounds, other people talking	
Crawled		Babbled	
Self-fed		Said real first words	

Did (s) he ever stop/ regress in babbling/ talking? ☐ Yes ☐ No

Is his/her speech intelligible to people outside of the family? ☐ Yes ☐ No

Does anyone in the family interpret for the child? ☐ Yes ☐ No

Does the family access interpreter services? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY:

Has your child had any serious illness or accidents? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Did any of these illnesses seem to change the child's development or behavior? ☐ Yes ☐ No If yes, please describe:

_____

Describe any injuries and/or surgeries (give age and severity): _____

_____

Does your child have any vision issues? ☐ Yes ☐ No If yes, please describe: _____

Please list current medications:

Drug name:	Dose/amount:	Reason:

Please indicate any services this child has received:

☐ Bilingual Education ☐ Occupational Therapy ☐ Early Childhood Education

☐ Physical Therapy (PT) ☐ Special Education ☐ Interpreting

☐ FM System ☐ Reading Specialist ☐ Social Services/Mental Health

☐ Speech-Language Therapy ☐ 504 or IEP

☐ Other: _____

NOSE AND THROAT HISTORY:

Has your child ever had an ear infection? ☐ Yes ☐ No

If yes, how frequently? _____

When did they start? _____

When was the last one? _____

Has she/he ever had draining ears? ☐ Yes ☐ No

Has he/she ever had ear surgery? ☐ Yes ☐ No If yes, please explain: _____

Does wax accumulate rapidly in ears? ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No

Does your child mouth breathe? ☐ Yes ☐ No

Does your child have his/her adenoids and tonsils? ☐ Yes ☐ No

Has your child ever had a hearing test/evaluation? ☐ Yes ☐ No If yes, state when and where results? _____

_____

FAMILY HISTORY:

Do family members have any of the listed issues? If yes, please share who:

Disabilities or special conditions	Check for yes	Relationship to child
Hearing loss		
Autism Spectrum Disorder		
Mental Health (if yes, please describe)		
Specific learning disability		
Speech impairment (if yes, please describe)		
Fragile X		
Developmental Delay		

What languages are spoken in the home? _____

What is the primary language of the child? _____

Please describe any cultural habits/ home issues that may affect your child's behavior: _____

MISC:

What comforts your child? _____

Signature of parent/guardian: _____ **Date:** _____