YOUR CHILD'S HEARING HISTORY

Name_____ **Birthdate**_____**Today's Date:**_____
How did you hear about us?_____To whom should reports go: _____

Reason for current visit
What is the purpose of today's visit? (What are your concerns?) _____ _____ Identify concerns of teachers, or family members, about your child's hearing: _____ _____

Yes	**No**	**Specific questions about your child's hearing history**
☐	☐	1. Does your child respond to sound consistently?
☐	☐	2. Do you repeat often for your child to understand?
☐	☐	3. Does your child like to sit close to the TV or does he/she turn up the volume?
☐	☐	4. Has your child had a formal hearing test by an audiologist? When & where?
☐	☐	5. Does anyone in your family have a hearing loss?
		Specific questions about your child's ear history
☐ ☐	☐ ☐	1. Has your child had ear infections? If yes: a. Did they occur in the first 18 months of life? How many?_____ b. At what age did the first ear infection occur?_____How many since then?_____ c. When did the last ear infection occur? _____ d. How long does it take for an ear infection to clear?
☐	☐	5. Is your child currently taking antibiotics for an ear infection?
☐	☐	6. Has your doctor ever reported fluid behind your child's eardrum?
☐	☐	7. Has your child complained of pair, discomfort, or ringing in the ears?
☐	☐	8. Has your child had any balance, nausea or dizziness problems?
☐	☐	7. Has your child ever been seen by an ENT physician?
☐	☐	8. Has your child ever had pressure equalizing tubes for chronic ear infections? How many sets of tubes? _____At what ages? _____

Hearing aid history: if your child has ever worn a hearing aid, please answer the following
1. Does your child wear one now? What make and model
2. When did your child first start wearing a hearing aid?
3. When did you purchase the present hearing aids?
4. Have the aids been satisfactory or unsatisfactory and why?
5. How many hours a day are they worn?
6. How often do you replace the batteries?
Social/developmental History
1. How well does your child interact with others his/her own age?
2. Describe progress in school
3. At what age did your child Walk? _____ Say his first word? _____ phrases? _____

Specific questions about your child's general health & medical history
Check any of the following that your child currently has or has had:

Frequent colds		Head trauma		Holes in eardrums	
High fevers/serious illness		Difficulty breathing		Transfusions	
Seizures/convulsions		Birth complications		Jaundice	

1. List any chronic illnesses: _____
2. List all current medications: _____
3. List any surgeries: _____
4. Describe any problems with your pregnancy or delivery with this child:_____
   _____
5. Circle any of the following that apply to your pregnancy: premature delivery Rh factor
   TORCH infection Birth complications Illness during pregnancy
6. What was the baby's birth weight? _____ APGAR at 1 minute? _____at 5 minutes?_____

Thank you for helping us help you hear better! Please return this form to the front desk.

SIGNATURE PAGE

Instructions: Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			CONSENT FOR TREATMENT I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, *I accept personal liability for the charges not reimbursed by Insurance within 45 days.*
			AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of relevant diagnostic, therapy , or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* **(**you may refuse to sign this acknowledgement) I have received a copy of this office's *Notice of Privacy Practices.*

_____ _____

Signature Date Witness

MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cann not bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

_____ _____ _____

Patient Name Date Parent/Guardian Signature/Date Witness

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

PATIENT HEALTH QUESTIONNAIRE: *modified*

NAME: _____ **DATE: _____**

Instructions: How often have you been bothered by each Of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.	**(0) Not at all**	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?				
7. Trouble concentrating on things, like school work, reading or watching TV?				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
( ) Yes ( ) No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take are of things at home or get along with other people:
( ) Not difficult at all ( ) Somewhat difficult ( ) Very Difficult ( ) Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
( ) Yes ( ) No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
( ) Yes ( ) No

** *If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

CLINICAL DEPRESSION FOLLOW UP PLAN

Document on the date of the positive screen

Patient Name: _____ *Date:* _____

	Referred for additional evaluation for depression to :
	Suicide Risk Assessment referral by:
	Referral to practitioner who is qualified to diagnose and treat depression:
	Pharmacological interventions:
	Other interventions or follow up for the diagnosis or treatment of depression:

Patient is <u>not</u> eligible if one or more of the following conditions are documented. Check all that apply

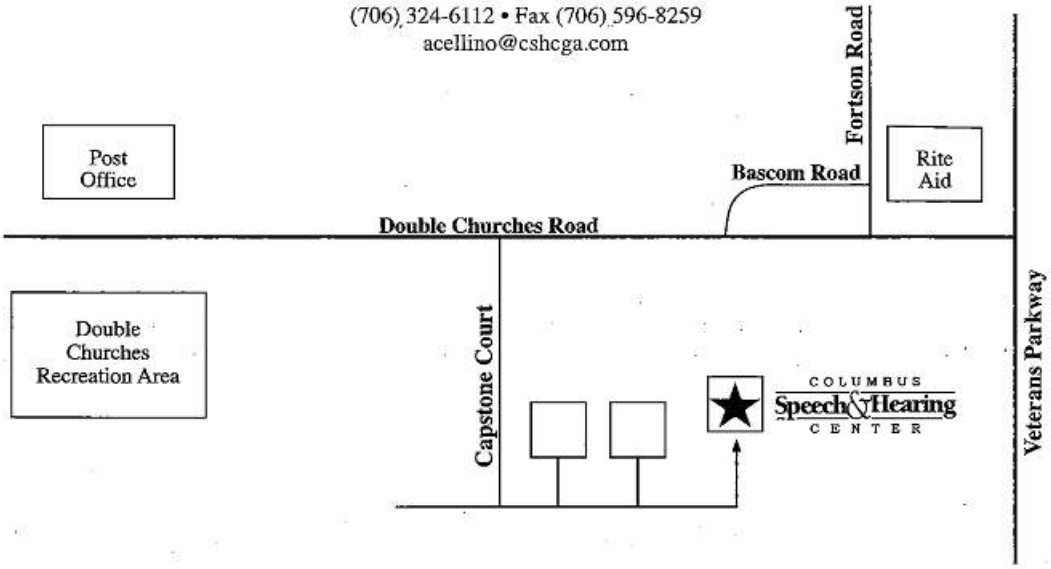
	Pt has active diagnosis of Depression or Bipolar Disorder
	Pt refuses to participate
	Pt is in urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
	Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

_____

Examining Audiologist

Directions to Columbus Speech & Hearing Center

COLUMBUS
Speech & Hearing
CENTER
2424 Double Churches Road • Columbus, GA 31909
(706) 324-6112 • Fax (706) 596-8259
acellino@cshcga.com



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left