OUR LADY OF THE LAKE UNIVERSITY
Woolfolk School of Communication Sciences and Disorders

HARRY JERISG CENTER, 411 S.W.24TH Street, San Antonio, Texas, 78207, Phone: 210.431.3938

Thank you for contacting the Harry Jersig Center regarding speech/language services and we hope to have the opportunity to address your child's communication needs. Please understand that this is a teaching clinic (Communication Sciences and Disorders) which requires that clients be admitted based upon the clinical experiences needed by our graduate students. Completion of the intake form will allow us to determine if/when your child will receive services in our clinic.

Completion of this form is the first step in the admittance process. You will be notified of your application status and further requirements via e-mail and/or phone.

Fees for Services.
Currently, there is no fee for services, however donations are welcome to help the clinic maintain materials, and clinic upkeep for client services.

Student involvement.
As part of the Woolfolk School of Communication Sciences and Disorders at Our Lady of the Lake University, the Harry Jersig Center is a training facility for graduate students studying to be speech pathologist. Therefore, most of our services are provided by university students under the supervision of state licensed and nationally certified speech-language pathologists. We operate on a university calendar, and services are provided on a semester basis, i.e. Fall (Sept-Dec), Spring (Jan-May), Summer (JunJul).

Admission Process.
After completing this intake for evaluations or treatment, please follow the procedures listed below:

1. Bring, mail, e-mail or fax the completed packet to the Harry Jersig Center at Our Lady of the Lake University.
    - E-mail: jersigcenter@ollusa.edu
    - Fax: 210.434.9360
2. If you are interested in services, you will be contacted to set up an appointment time.
3. If you have more questions about our services, please contact Rosa Lydia Martinez (Clinic Director at ext.6590).

Please note that admission is dependent on availability of appointment times.

We hope this information will be of use to you, and that you feel free to call us if you have any further questions.

Sincerely,

Rosa Lydia Martinez, M.S., CCC-SLP

Rosa Lydia Martinez

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Pediatric Intake Form

Please fill out this form as completely as possible, especially the items marked with an asterisk. If you need more space,attach another page, or write on the back. Call 431-3938 if you have additional questions regarding these forms.

Date Intake Completed:_____

Child's Name:_____

Date of Birth:_____ **Age:**_____ **Grade:**_____ **Gender:**_____

Guardian(s):_____ **Relationship:**_____

Cell Phone:_____ **E-mail:**_____

Referred By:_____

Pediatrician:_____ **Phone Number:**_____

Which of the following services are you requesting?

DIAGNOSTIC SERVICES	Please check services that apply	TREATMENT SERVICES	Please check services that apply
Speech-Language Evaluation		Speech-Language Therapy	
HEARING EVALUATION		Individual therapy	
HEARING AID EVALUATION		Early intervention group	
SWALLOWING EVALUATION		Aural rehabilitation	
VOICE EVALUATION		Other:	

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Please provide doctor's written referral if needed.

What are your expectations from this appointment?

☐ Speech-Language developmental level

☐ Recommendations for things I can do at home

☐ Enrollment in therapy or classes

☐ Other (Please explain below)

_____

_____

Does your child have:

☐ Difficulty being understood
☐ Difficulty producing some speech sounds
☐ Difficulty understanding what is said
☐ Difficulty expressing wants, needs, thoughts, and/or ideas
☐ Academic difficulties/concerns
☐ Difficulty producing smooth and connected speech
☐ Hearing difficulties/concerns
☐ Difficulty feeding and/or swallowing
☐ Difficulty with behavior and/or self-regulation at home or school
☐ Difficulty with attention, memory, organization, task completion, and/or planning
☐ Difficulty interacting socially with others
☐ A need to use technology and/or AAC device to communicate

How did you become aware of the Harry Jersig Center?

☐ ENT
☐ Internet
☐ Teacher

☐ Pediatrician

☐ Friend

☐ Neurologist

☐ Speech-Language Pathologist

☐ Other (Please specify below)

History of Problem

Describe present problem:_____

Who noted present problem:_____ **When?**_____

What is your child's reaction to the problem?

_____

_____

How does the family react to the problem?

_____

_____

Has there been any significant change in the last six months?_____

If so, what? _____

How well is your child understood by: (i.e., what percentage of the time)

Mom:_____ **Dad:**_____ **Younger siblings:**_____ **Older Siblings:**_____

Other children:_____ **Extended Family:**_____ **Unfamiliar Adults:**_____

Describe what it is like to have a conversation with your child:

Any previous assessments? Y N Where?_____ By whom?_____

What kind? _____

What were the results?

Which tests were given? _____

Any previous therapy? Y N Where?_____

With whom? _____

Birth History

What was the length of the pregnancy? _____

Were there any illnesses or accidents during pregnancy? (Explain)

Were drugs or alcohol used during pregnancy? (aspirin and/or medication) Y N

If so, what? _____

What was the length of labor? _____

Any difficulties at birth, including Caesarian? (describe):

Were drugs used? _____ Instruments? _____ Bruises to head?_____

What was the mother's age: _____

Mother's health at time of pregnancy and birth was? _____

What was the final Apgar Score? _____

Any jaundice? Y N Cyanosis? Y N Rh incompatibility factors? Y N

Medical History

***Please check if your child has had any of the following (and if so, at what age):**

☐ **Seizures**	☐ **High Fevers**	☐ **Measles**	☐ **Mumps**
☐ **Chicken Pox**	☐ **Whooping Cough**	☐ **Diphtheria**	☐ **Bronchitis**
☐ **Pneumonia**	☐ **Tonsillitis**	☐ **Meningitis**	☐ **Encephalitis**
☐ **Rheumatic Fever**	☐ **Tuberculosis**	☐ **Sinusitis**	☐ **Chronic Cold**
☐ **Enlarged Glands**	☐ **Thyroid**	☐ **Asthma**	☐ **Heart Trouble**
☐ **Chronic Laryngitis**	☐ **Diabetes**	☐ **Head Injuries**	

Please explain any checked items here:

_____

_____

Are immunizations current? _____

Current general health? _____

Has your child had any earaches/ear infections? Y N

Please explain here: _____

Allergies? (Describe) _____

Any other serious or recurrent illness? **Y N** **When?**_____

Any operations? **Y N** **When?**_____

Any accidents? **Y N** **When?**_____

Any medication? (Past)_____ **(Current)** _____

Hearing difficulties? _____**Treatment:** _____

Vision problems? _____**Treatment:** _____

Dental problems? _____**Treatment:** _____

Other Medical History:

_____

_____

****** If your child has had chronic ear infections and/or had tubes placed in his or her ears, please attach or have a statement sent from you doctor regarding dates and results of treatment.***

Personal Medical Information

Personal Primary Physician: _____

Date of last visit: _____

Address or Location: _____

Ongoing Medical Care (Describe):

_____

_____

City of ongoing care: _____ **Physician's Name:** _____

Current Medications:_____

Dosage: _____

Chronic Health Problems: _____

Handicaps: _____

Developmental History

Age when child: (If you can't remember a specific time, please indicate if it occurred at the expected time or was delayed)

Sat up alone: _____ **Crawled:** _____ **Walked:** _____ **Toilet Trained:** _____

Dressed Self: _____ **Tied Shoes:** _____ **Fed Self Independently:** _____

Is the child left or right-handed? _____

Attention span for self-directed activities:

Does your child respond to:

Light? _____ **Sound?** _____ **People?** _____

Does your child:

Play with others? _____ **Who?** _____

Eat and sleep well? _____ **Smile?** _____ **Cry appropriately?** _____ **Laugh?** _____

Make wants known? _____ **How?** _____

Does your child show unusual behavior (explain)?

_____

_____

_____

Speech and Language

Language(s) spoken in the home: _____

Age when your child spoke first word: _____ **Combined words:** _____

Spoke in sentences:_____

What was your child's first word(s)? _____ **First sentence?** _____

Which sounds (if any) are incorrect? _____

How many words can your child say? (list if fewer than fifteen)

_____

_____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? _

_____

_____

Does your child have difficulty following directions?

_____

_____

Any speech or hearing problems in the immediate or extended family? (explain)

_____

_____

Social Development

Names and ages of siblings: _____

Other adults living in the home: _____

Moves prior to age 10: _____

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Has your child attended day care? _____ Nursery School? _____ Ages: _____

Number of regular playmates: _____

Activities shared with parents/siblings: _____

How does your child handled:

Conflict? _____

Separation? _____

Regular Responsibilities? _____

What are your child favorite:

Places? _____

Toys?_____

Snacks? _____

Activities? _____

TV Program? _____

What motivates your child most?_____

What discipline methods work best?_____

School History

School Experience: _____

How does your child's teacher describe his/her performance?

_____

_____

Has the teacher expressed any concern? If so, what?

Other

What are your expectations for this evaluation?

Does the report need to be sent to specific agencies? _____

If so, where?

Anything else you would like us to know?

***** Thank you for your time, and the care with which you filed out this form. We look forward to helping you and your loved ones.**

Please email this completed form to jersigcenter@ollusa.edu or mail to Harry Jersig Center.

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AUTHORIZATION OF RELEASE OF INFORMATION OBTAINED DURING TREATMENT OF ASSESSMENT

1. I hereby authorize the agents of the Harry Jersig Communication Disorders Program, exercising due discretion, to use the following items (circled) of either myself or my child, for whom I am legally responsible.

   A. Make audio recordings of sessions. Yes No

   Make video recordings of sessions. Yes No

   Take photographs during sessions. Yes No

2. I authorize that you use these not only as a record of the session, but also for the following:

   A. For clinical purposes (e.g., verification of data collected) Yes No

   For educational observations (e.g., classroom demonstration) Yes No

   For professional research. Yes No

   For public meetings (e.g., high school career day programs, science fairs, club meetings or booth displays, HJC website, etc.) Yes No

   For purposes of public relations or news media (e.g., newspapers, Website, newsletter, television, information brochures) Yes No

   Authorize live observations of sessions by students in the Communication Disorders Program at OLLU. Yes No

   To ALL of the above. Yes No

Signature of client, parent and/or guardian: _____

Relationship to client: _____

Release date authorized from:

_____Start date of therapy and after the end date of therapy for reasons circled above

_____Start date of therapy to end date of therapy for reasons circled above

Client's name: _____

Date of Birth: _____

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Harry Jersig Center at the Our Lady of the Lake University to release/request the following information from the health record(s) of:

Patient Name: _____ DOB: _____

Address: _____

City, State, & Zip Code: _____

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 {45 CFR & 164.508}.

1. I authorize Harry Jersig Center, Our Lady of the Lake, to request copies of the following types of records from:

   _____

   _____

   ☐ Complete health records

   ☐ Speech and Language evaluations

   ☐ Audiological and/or Ontological records

   ☐ Observation of child in classroom

   ☐ Educational records, including achievement test scores, individual Academic/Psychometric Evaluations, Psychological Evaluation, ARD/IEP

2. I authorize the Harry Jerisg Center at Our Lady of the Lake University to release the following tyoe(s) or records to: _____

☐ Speech and Language records

☐ Audiological records

I understand this consent can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Specification of the date, event, or condition upon which is consent expires _____.

The facility, its employees and officers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____

Signature (Self/Parent/Guardian)

Please Print Name: _____