Welcome to Central Missouri Therapy Spot
Social Skills Group

The social skills preschool program focuses on intense speech and language therapy embedded in a preschool structure. Integration of typically developing same aged peers are incorporated into each session to further enhance the peer model influence. All therapy is in a small group, play based and incorporates all areas of development. Each child will have goals for expressive language, receptive language, cognitive skills, social skills, play skills and literacy development. These goals will be addressed in a small group setting led by a licensed Speech Language Therapist (4 children for 1 therapist).

Our sessions are focused on a whole child approach; while speech and language is targeted, all activities will involve skills which enhance gross motor skills (song and dance), fine motor skills (art and crafts) and sensory integration.

Each child will be screened in all areas of development: those screenings may indicate the further need for therapy services. These screening tools are used to identify potential signs/need areas for further evaluation. This is simply a recommendation, not a requirement. We are happy to answer any questions you may have regarding those screenings. Your child's first comprehensive screening will be within the first 4 weeks of session. At that time all caregivers will be invited to discuss those screenings and add any information/goals that they may have.

Like us on Facebook! We love to share pictures (with permission) and updates on what we are learning/doing at the center. This is a great way to see your child in action.

Contact us with any questions/concerns at any time. Our email is: admin@therapyspotmo.com

Items included in this packet include:

_____Intake Form
_____Authorization for medical attention
_____ Consent for treatment
_____ Policy and Procedures
_____Photo Release
_____Privacy Practices

Central Missouri Therapy SPOT will be obtaining a script from your pediatrician for your child to receive services by a licensed therapist.

Please return all items prior to your child's start date. Your child is scheduled to start on: _____

Central Missouri Therapy Spot
Intake Form

I. Identifying Information

Child's Name _____Nickname_____ Age _____ Birth date _____
Male _____ Female _____
Child's Home Address:
_____
(Street, City, State, and Zip)
Name of Parent/Guardian _____
Relationship to child _____
Occupation: _____
Phone: Home ( ) _____ Work or Cell ( ) _____
Email _____
Name of Parent/Guardian: _____
Relationship to child:_____
Address (if different than above): _____
Occupation: _____
Phone: Home ( ) _____ Work or Cell ( ) _____
Email: _____
Who does your child live with? (Check all that apply.)
□ both parents □ grandparents □ mother only □ foster parents
□ father only □ parent + stepparent □other _____
Are languages other than English (including sign language) used at home? _____yes _____no
If Yes, what language (s)? _____
Preferred method of contact for communications, notifications and announcements.
_____ Text: Phone number preferred: _____ _____ Email _____ Call

II. Referral/ Insurance info

How did you hear about our program? _____
Do you have concerns about your child's speech and language development? _____ yes _____ no
If yes, please explain: _____
_____
_____
Is/Has your child received speech/language and/or developmental services? _____ yes _____ no
Has your child been evaluated by any other professional? (Check all that apply.)
□ Speech-language pathologist □ educator/teacher
□ Occupational therapist (OT) □ neurologist
□ Physical therapist (PT) □ physician
□ developmental pediatrician (specialist) □ geneticist
□ psychologist/psychiatrist □ other_____
Any other relevant evaluations? _____yes _____no
If yes, please list _____
Please provide us with a copy of any evaluation reports you may have.
Boone County Family Resources Service Coordinator, if applicable: _____
First Steps Therapist and Service Coordinator: _____

Insurance: Medicaid: yes or no/ If yes, what type:_____
Medicaid DCN#:_____
Do you also have private insurance? Yes / No
Name of Insurance Company: _____
Policyholder name:: _____
Policyholder Date of Birth:_____
Policyholder ID # or SSN:_____
Group #: _____
On the back of the card: Provider phone #:_____

III. Home and Family

Please list siblings and other members of the household (not listed on page 1) :
Name, Date of birth, Age, M/F, Relationship to child

_____
_____
_____
_____
_____

Do any of the above individuals have speech, language or hearing problems? _____yes _____no
If yes, please explain: _____
Are there any other family members (grandparents, cousins, etc) that have a hearing loss or communication problem? _____yes _____no
If yes, please explain: _____

IV. Prenatal (pregnancy) and Birth

Mother's date of birth _____ Father's date of birth _____
Length of Pregnancy in weeks: _____
Explain any complications during pregnancy: _____
Did you have a normal delivery with this child? _____yes _____ no
If no, please explain: _____
□typical □spontaneous □induced □Cesarean □breech □unusually long labor
Were there any problems or complications immediately following birth or during the first two weeks of your infant's life? (feeding, seizures, sleeping, swallowing, hospitalizations, etc.):

_____
What was your child's birth weight? _____

Check if any of the following problems occurred after the child's birth.

- ❑ Trouble breathing
- ❑ Floppy
- ❑ Incubator care
- ❑ Infection
- ❑ Other
- ❑ Cord around the neck
- ❑ Fever
- ❑ Hemorrhage (bleeding) in head
- ❑ Large ventricles (hydrocephalus)
- _ Vomiting
- _ Cyanosis (turned blue)
- _ Need for ventilation/oxygen
- _ Jaundice
- _ Poor feeding

V. Medical History

Name of child's Pediatrician/Doctor_____

Phone: _____

Address_____

List any past or current health problems your child has : _____

_____

Does your child have allergies (including food)? _____yes _____no

If yes, please elaborate: _____

Is your child currently on medication? _____yes _____no

If yes, please explain: _____

Do you have any concerns about your child's eyesight? _____yes _____no

If yes, please explain: _____

Does your child have a history of feeding problems? ____ yes ____no

If yes, circle all that apply.

□ choking □ difficulty biting □ overstuffing mouth

□ poor nursing □ difficulty chewing □ difficulty swallowing

Does your child have a history of trouble sleeping through the night? ___yes ____no

VI. Hearing

Yes No

___ ___ Do you feel your child hears well?

___ ___ Has your child ever had an ear infection? If so, which ear? _____

Last occurrence _____ First occurrence _____ Frequency_____

___ ___ Does he/she presently have or is the past had draining ears?

___ ___ Does he/she wear hearing aids? If Yes: Make and model _____

When did he/she receive the hearing aids? _____

___ ___ Has your child ever had a hearing test? If yes, when? _____

Results? _____

Does your child appear to attend to your face when listening? ___ yes ___no

Does your child appear to become distracted easily when listening? ___yes ___no

Does your child appear to be particularly uncomfortable in noise? ___yes ___no

VII. Development

Was your child breast-fed? ☐ Yes ☐ No

Duration?_____

Describe the circumstances around stopping: Describe the weaning:

_____

Was your child bottle-fed? ☐ Yes ☐ No Duration?

_____

Describe the circumstances around stopping:

_____

Please check any of the following that described your child as an infant:

☐ Fussy ☐ Easy to soothe ☐ Difficult to soothe ☐ Startled easily ☐ Sleeping problems

☐ Feeding problems ☐ Cried excessively ☐ Colic ☐ Reflux ☐ Failure to thrive ☐ RSV

☐ Other

What are your child's sleeping arrangements?

☐ room alone ☐ with sibling ☐ with parents ☐ with others

Does your child sleep in: ☐crib ☐bed

Does he/she sleep through the night? ☐Yes ☐ No
If not, how many times does he/she awaken at night? _____
For how long?_____
What helps him/her get back to sleep?
_____
Did/does your child have a special object (blanket, teddy bear, etc.)? ☐ Yes ☐ No
If yes, please describe
_____
If yes, until what age?_____
Does he/she have any self-soothing behavior? ☐Yes ☐ No
If yes, does he/she: ☐ suck fingers/thumb ☐ use pacifier ☐ other, please describe
Does your child exhibit any behaviors that you consider 'odd' or
''unusual'?_____
How many hours of TV, phone, Ipad, and/or video does your child watch each day? _____
What are his/her favorites?
_____

In your opinion, is your child typical for his/her age in:

Self Help Skills		Social Skills	
Eating	yes____no_____	playing with peers	yes_____no_____
Toileting	yes____no_____	general social interactions	yes_____no_____
Dressing	yes____no_____		

Please explain any areas checked "no" _____
For toileting, what kind of help and/or what words or gestures will your child be using?
_____
In your opinion, is your child typical for his/her age in:

Walking	yes_____no_____	coloring	yes_____no_____
Running	yes_____no_____	cutting	yes_____no_____
Jumping	yes_____no_____	building with blocks	yes_____no_____
Going up stairs	yes_____no_____		
Throwing/catching a ball	yes_____no_____		

Please explain any areas checked as "no": _____
Would you describe your child's coordination as: _____good _____fair _____poor?
At what age did your child attain these developmental milestones?
sitting _____ walking _____
crawling (Please also indicate if there was minimal time spent in the crawling phase)
_____ toilet training_____
Is your child a messy or picky eater? ____yes ____no
Please list favorite foods: _____
Please list food sensitivities: _____
What does your child drink from? ____Sippy cup ____open cup _____uses a straw
other _____
Does your child dislike having substances on his/her hands such as glue or dirt? ___yes ___no
Is your child oversensitive to being touched/dislikes being touched? ___yes ___no
If yes, please describe _____

Check all that apply regarding your child, if any.

□ dislikes washing his/her face or hair □ does not demonstrate caution
□ dislikes haircuts □ puts things in his/her mouth besides food
□ spends too little time or too much time brushing his/her teeth □ chews on his/her clothes

VIII. Communication Skills and Cognition

What does your child use the most? _____ complete sentences _____ phrases
_____ one or two words _____sounds _____gestures
_____ physically takes adult to item _____augmentative communication system
At what age did you child say his/her first word? _____
What were the child's first few words? _____
Approximately how many words did your child have at… 18 months? _____ 24 months? _____
At what age did your child say his/her first sentence? _____
Give some examples of first sentences: _____
Give an example of typical sentences the child currently uses: _____
Did speech-language learning ever seem to stop for a period? _____
Estimate the percentage of time that your child is understood by:
_____parents _____other adults _____brothers and sisters
_____friends
Please indicate your child's level of understanding of others by checking those that apply:
_____understands gestures _____does not understand spoken words _____understands single words
_____understands simple sentences ____understands 2 and 3 part commands _____understands conversation

How does your child understand and use language? Please circle all that apply

Cries
whines
grunts
Gestures
Babbles or uses jargon
Single words
Putting words together
Uses 3 to 5 word sentences
Is difficult to understand
Follows oral directions
Can point to objects and pictures named

Does your child typically display any of the following behaviors? (Check all that apply.)

□ reduced or lack of interaction with others
□ tantrums
□ sensitive
□ underactive
□ shy
□ difficulty finishing tasks
□ very active
□ frustrated
□ refuses to perform tasks
□ difficulty staying on task
□ passive in interactions
□ angry/acting out behavior
□ inattentive

IX. Sensory Development

Is your child overly sensitive to sensory experiences (e.g., sounds in restaurants, textures, bright lights, smells)?
If so, please explain:

_____

Does your child take longer to react or not react to sensory experiences (e.g., appears to be in his/her own world, does not respond to his/her name when called)? If so, please describe:

_____

Does your child seem to actively search or seek out sensory experiences (e.g., constant desire for pushing, pulling, and hanging off things; constantly on the move; seems unable to stop talking; touching people to the point of irritating others)? If so, please describe:

_____

Does your child have a difficult time distinguishing sensory experiences? (e.g., trouble distinguishing objects in pockets, trouble recognizing objects by their shape, trouble differentiating smells). If so, please describe:

_____

Does your child seem clumsy (trips/falls frequently) when executing movement, performing unfamiliar movements or completing tasks with multiple steps? If so, please describe:

_____

Does your child have poor balance during motor activities (e.g., biking, karate, and gymnastics)? If so, please describe:

_____

Does your child have difficulty sustaining adequate posture at a desk/table (slumps, leans on arm, head too close to work, props head on hands)? If so, please explain:

_____

X. Day Care and School Experiences

Does your child attend: _____daycare _____preschool _____other?
Name of daycare or school _____
When is he/she in the daycare or preschool program?

_____

How does your child relate to children in their own age group? _____
Other programs your child has attended: _____

Does the teacher describe your child with any of the following comments (please check):
Cannot follow directions ☐ Cannot sit still ☐ Seems to be daydreaming ☐
Learns best using multi-sensory approach ☐ Learns best auditorily ☐ Learns best visually ☐
Picks on other children ☐ Is aggressive ☐ Is sneaky Has a difficult time expressing his/her thoughts ☐
Doesn't seem to comprehend what's said ☐ Cannot complete tasks ☐

XI. CURRENT CONCERNS:

Please check below if you have any concerns about your child in these areas:

☐ Short attention span	☐ Impulsivity	☐ Low frustration tolerance	☐ Oppositional behavior
☐ Aggression	☐ Difficulties with transition	☐ Attention seeking	☐ Hyperactivity
☐ Noncompliance	☐ Social isolation	☐ Lying	☐ Distractibility
☐ Avoidance	☐ Anxiety	☐ Low self-esteem	
☐ Awareness of differences	☐ Difficulties separating	☐ Self-stimming	

Please list any additional concerns about your
Child:_____

When did these problems begin? _____

XII. Other

How would you describe your child? Reserved? Confident? Assertive? _____

How does your child react when he/she is upset or sad? _____

What is the best way to comfort him/her? _____

How does your child deal with frustration? _____

What strategies do you employ? _____

How does your child deal with separation? _____

List a few of your child's favorite activities: _____

Does your child have any pets? (Real or favorite stuffed animal)_____

What other concerns do you have about your child? _____

_____

What do you consider to be your child's greatest strengths? _____

What do you hope to gain from this evaluation and participation from the program?

_____

What do you hope your child will gain from the program?

_____ Language stimulation _____learn more English _____socializing with peers

_____ a general preschool experience _____ to correct speech & language problem

other _____

All information will be held in strict confidence and not released to any person(s) without explicit authorization nor shared with any unauthorized person.

The Speech and Language Center

Authorization for Emergency Medical Attention

Child's name (print): _____ Date of birth: _____

Mother's cell #: _____
Mother's work #: _____
Mother's home #: _____

Father's cell #: _____
Father's work #: _____
Father's home #: _____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize The Speech and Language Center to take my child to the location listed below, or to the nearest hospital, and we give our consent for any and all necessary treatment:

Doctor: _____
Address:_____
Phone #: _____

In case of emergency treatment, please inform the medical staff that our child has the following allergies and takes the following medication(s) on a daily basis (including dosage):

Allergies: _____
Medications: _____

Please list two (2) people who we may contact in the event of an emergency:

Name: _____ Phone #: _____
Relationship: _____

Name: _____ Phone #: _____
Relationship: _____

Signature: _____
Date: _____

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES

The Speech and Language Center

Consent for Treatment

Client: _____

Date of Birth: _____

Parent/Guardian: _____

Relationship to Client: _____

I, _____, hereby give consent for the above named child and/or myself to receive services at The Speech and Language Center. This consent is given until I give notice that these services are no longer requested or untilThe Speech and Language Center professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to The Speech and Language Center professionals is confidential and will generally be released to others only with my written consent. I understand that The Speech and Language Center professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of The Speech and Language Center professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against The Speech and Language Center professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through The Speech and Language Center are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

Signature of Parent/Guardian: _____

Date: _____

Publicity and Photo Release

From time to time, we may take pictures and/or video images of The Speech and Language Preschool Center programs and the people we support. These images may then be used for specific internal and external purposes, including marketing, fundraising, and publicity, including Facebook. Personal identification will not be released with any photos and/or videos. However, these images may be used only with the consent of the individual begin photographed or videotaped.

Please sign and ( ) either statement #1 or #2 below to indicate your preference in this matter.

1. ( ) I give my permission for pictures and video images to be taken of

   _____.
   Child's Name (please print).

2. ( ) I choose not to have any pictures or video images taken of my child.

   _____.
   Child's Name (please print)

( ) I have read the above statement of consent and understand it fully. I do hereby give consent as indicated in the release. It may be revoked by me in writing at any time.

_____ _____
Signature Date

Please read each policy and initial. Thanks!

Authorize Pick Up Policy

Our normal procedure is to release the child to his/her parents, or someone else the parents designate on the Authorized Pick up and Emergency Contact Form. If someone other than the parent is to pick up the child, please notify us ahead of time. A verbal notice is fine on that day, if this person is on the list of people who are authorized to pick up your child. If the person is NOT on that list, we MUST have written permission to release your child. Please inform emergency contacts, or people designated to pick up your child, that if we do not know them then we will need to ask for identification. This is not meant to offend them. This is simply a measure taken for the child's protection.

Initials _____

Tuition

Tuition is based on enrollment (a reserved space), not on attendance. To maintain a reserved space, fees must be paid during the absence of a child due to illness, holidays, vacation, or for any other reason. If a child does not attend the family/caregiver is responsible for that months session rates. If the child does not attend, and the child receives third party funding, the funding may not be accessible. In that event, the family/caregiver is responsible for that months session rates.

Payment is expected every Monday/Tuesday, prior to the session beginning. In the event of a returned check, there will be a $25 fee.

Initials _____

Withdrawing Policy

On occasion, it may be necessary for a child to withdraw from The Speech and Language Center. In this event, **parents must notify the director prior to the month of withdraw.** If withdraw occurs once the month of services begins, the family/caregivers will be responsible for payment of that months services. whether or not the child is in attendance. In the event that payment is not made prior to withdrawing, parents will be notified by certified letter.

Initials _____

Sick Policy

We will do everything we can to keep a healthy environment for your children. We ask for you to help us and the other families by complying with a few health guidelines. Please advise us whenever a member of your family has an illness, so that I can be alert to the possibility of symptoms developing in your child or the preschool class.

Your child should not come to The Preschool if they have any of these symptoms:

- A fever of 100 or higher currently or within the last 24 hours
- An unidentified rash, any open sores or weeping wounds
- A harsh cough or large amounts of yellow or green nasal discharge
- Lethargic behavior (moms usually know when the child isn't feeling well)
- Diarrhea or loose stools currently or within the last 24 hours
- Vomiting currently or within the last 24 hours
- Head lice, pinworms, pinkeye, ringworm, impetigo, etc.

We will not administer any medication (OTC or prescribed) to your children. We are sorry if this presents a scheduling issue for your child and are happy to have you come to The Preschool to treat them. We also would ask that you not leave any medications in the classroom with your child or in your child's bag.

Initials _____

Closings due to Weather

We make every effort to remain open during inclement weather. Our goal is to make sound decisions based on the safety of families and staff. We DO NOT follow any school districts closings decisions. We will notify each family via phone call or text and notification will be posted on our Facebook page as soon as a decision is made regarding the severity of the weather and road conditions. If we are closed due to inclement weather, you will not be charged for that day. We will do our best with scheduling to make it up at a later time.

Initials _____

Late Pick-up Policy

We understand that at times situations may arise that impact the ability to pick up your child in a timely fashion **(10 minutes or more after session ends)**. Session times are firm. After each session all Specialized Therapists have additional clients appointments to report to. If your child is late for pick up on two separate occasions a late pick up fee will be applied of **$25.00 per occurrence** thereafter. This fee will cover the cost of staff.

Initials _____

Child Pick-up Authorization

Name: _____

Relationship: _____

Phone #: _____

Additional persons who may pick up my child:

1. Name: _____

   Relationship: _____

   Phone #: _____

2. Name: _____

   Relationship: _____

   Phone #: _____

Note: Any person unfamiliar to us will be required to show proof of identification.

Signature:_____ Date: _____

HIPAA- QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Departments of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. The Speech and Language Center and Preschool Telephone: (573) 514-3525 Address: 4812 Santana Cir. E-mail: admin@thespeechlanguagepreschool.com I acknowledge that I have reviewed and agree to the Notice of Privacy Practices.

Parent Signature _____

Date _____

Childs Name_____

If you would like a copy of the HIPAA print out, please contact The Speech and Language Center at 573-514-3525

What is CoMO SEPTA?

A Special Education Parent Teacher Association (SEPTA) provides families and educators with an organizational structure, resources and the opportunity to be a collective voice for their special needs children. CoMO SEPTA has the benefit of reaching district-wide to bring together individuals with similar needs. We will be able to discuss issues, share resources, support our students and more.

Who is welcome to join?

Anyone with an interest in the welfare of students who access special education services in the Columbia, MO area is encouraged to join. Any type or level of disability, any age from preschool through high school, any classroom setting. Maybe you're a special education teacher, a therapist, or a general education teacher who has some students with special needs. Maybe you're a parent who's still looking into special education services, maybe you're a homeschooler who uses some special services through the public schools. Maybe you have a student who's in a typical classroom with some support, maybe you have a student who is in a self-contained classroom. We'd love to have you join us.

What makes a SEPTA different from a typical PTA?

The SEPTA will be focusing on parent support and education. We will have speakers on topics of interest, topics that are a problem issue, education about transitions between the various levels, and more. In addition, we are hoping to offer parent to parent support for IEP/504 or other school meetings. It is always helpful to talk with someone that has been through it and offer advice, or just an additional person to be at the table to take notes. We would also like to have time after the meetings for just general talk/support time, if anyone needs it that evening.

If I join CoMO SEPTA, should I still join my school's PTA?

Absolutely. Getting involved in both the school PTA and CoMO SEPTA is a great way to encourage inclusion and helps keep the lines of communication open to all parent groups. Families can then be a part of all school activities, ensure the inclusion of their children and still have their own format for the special supports and opportunities that they may see. Individual PTAs provide parent involvement opportunities and cover school-specific issues that CoMO SEPTA will not cover as a community-wide parent organization.

What is the membership fee?

The membership fee is $10 per person, with a discounted fee of $5 for an additional family member. Furthermore, you can provide a scholarship to cover the membership fee of someone else. We don't want to turn anyone away because of financial hardship, so let us know if you need assistance.

Who are our officers?

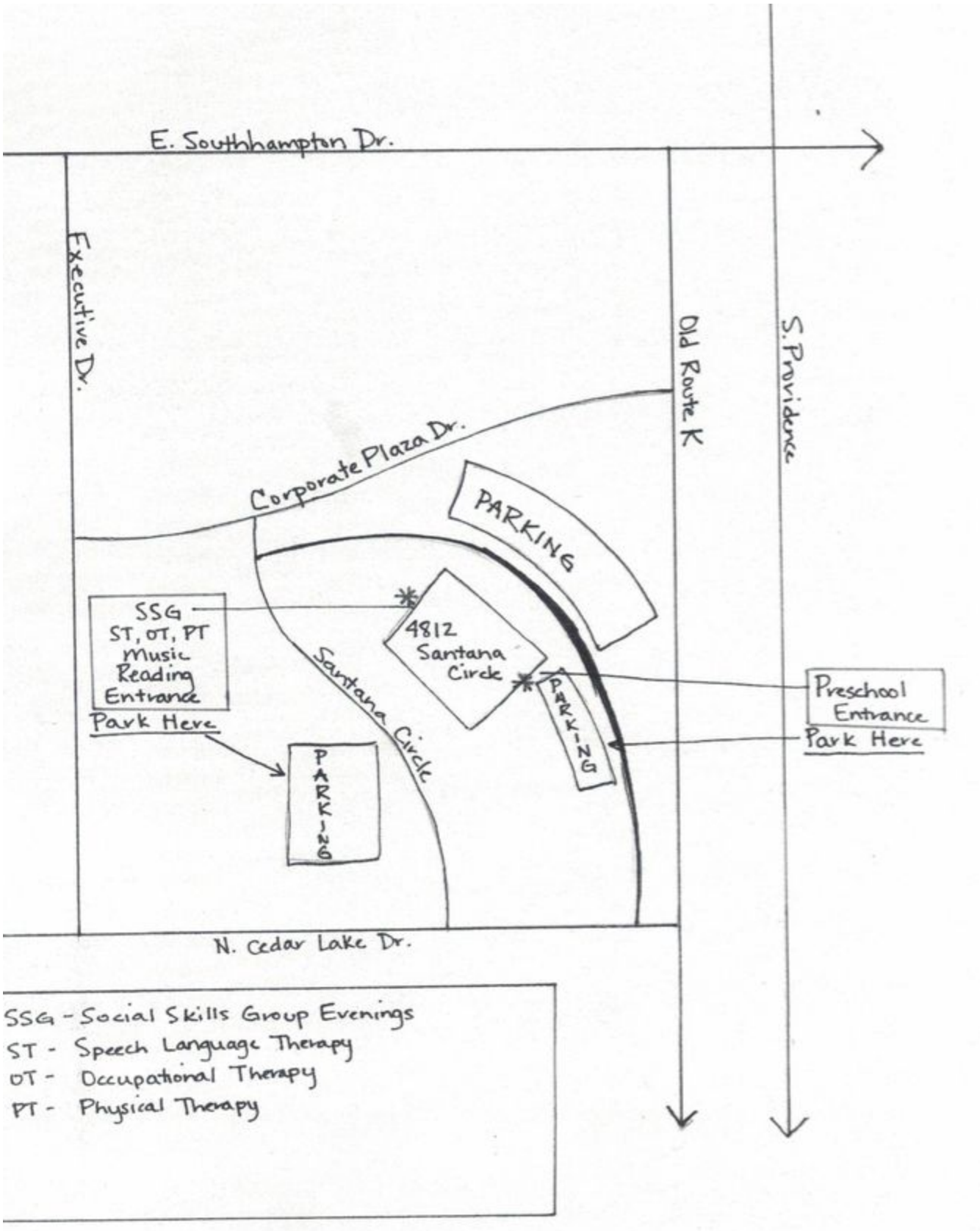
Michelle Ribaudo, President

Amie VanMorlan, Vice President

Tara Arnett, Treasurer

Kaitlyn Houston, Secretary

Contact us at comosepta@gmail.com, fill out our contact form, or let us know on Facebook.


E. Southhampton Dr.
Executive Dr.
Old Route K
S. Providence
Corporate Plaza Dr.
PARKING
SSG
ST, OT, PT
Music
Reading
Entrance
Park Here
4812
Santana
Circle
Santana Circle
PARKING
PARKING
Preschool
Entrance
Park Here
N. Cedar Lake Dr.
SSG - Social Skills Group Evenings
ST - Speech Language Therapy
OT - Occupational Therapy
PT - Physical Therapy