

Mize & Associates
803 Bayou Pines West Ste. E
Lake Charles, L.A. 70601
(337)-433-4212

Patient's Name: _____ Birth date _____

Address: _____ City _____ ST: _____ Zip _____

Person financially responsible for this account: _____

Parents Name-[Mother]: _____

Address: _____

Phone: _____ Cell: _____

Parents Name-[Father]: _____

Address: _____

Phone: _____ Cell: _____

Physician's Name: _____ Address: _____

Phone: _____

Nearest Relative not residing with you: _____ Phone: _____

Whom May we thank for referring you? _____

Informed consent agreement:

Please be prepared to pay your medical charges at the time of your office visit. All accounts are due and payable when the service is rendered. If statements are sent on open accounts, the payment is due within thirty days from the date of the service being rendered. If the account is referred to any attorney or collection agency, the patient hereby agrees to pay reasonable attorney's fees incurred and the cost of collection of 50% of this account. I/We agree to be bound by the above terms and conditions.

Authorization for release of medical records is hereby given. I understand that I am responsible for any amount of this evaluation\Screening.

Sign Date Method of payment CASH: _____
CHECK: _____

MIZE & ASSOCIATES, L.L.C.
Speech, Language, and Learning Center

803 Bayou Pines West, Suite E
Lake Charles, Louisiana 70601
Phone (337) 433-4212 · Fax (337) 433-4234

Myofunctional Therapy
Dysphagia Treatment
Learning Disabilities
Dyslexia Specialist

Maura Carmouche Mize, CCC-SLP
M.A. Speech Pathology
M.Ed. Early Childhood
LA License #1075

Certified by the American Speech-Language-Hearing Association

History

NAME: DATE:
ADDRESS: DATE OF BIRTH:
HOME PHONE: REFERRAL SOURCE:
MOTHER'S NAME: PHONE:
FATHER'S NAME: PHONE:
SIBLING'S:
NAMES AGE SEX HANDICAPS

OCCUPATION OF RESPONSIBLE PARTY:

EMPLOYER:

ADDRESS OF EMPLOYER:

CLIENT'S PHYSICIAN:

DESCRIPTION OF PROBLEM:

SIGNIFICANT FAMILY HISTORY:

Deafness:

Epilepsy or genetic disorders:

Mental illness:

Similar complaint in immediate family:

Educational: (child)

School:

Grade: Teacher: Average:

Previous testing or treatment by other professionals:

Academic tutoring, remedial work or therapy:

Prenatal and Birth History

Illnesses of Mother:

Rh incompatibility:

Accidents:

Previous miscarriages:

Length of Pregnancy: Birth weight:

Complications:

Client's Health Record

Diseases affecting the ear: (middle ear infections, tubes in ears, tonsillitis, etc.)

Surgery:

Allergies:

Seizures:

Accidents:

Is client presently being medicated for any condition? If so, what?

Physical Abnormalities:

Other:

Motor Development: Please indicate ages at which your child did the following:

Sitting up: Crawling: Walking:

Hand Preference: Toilet training:

Large muscle coordination: (running, jumping, throwing, catching, balancing, etc.)

Small muscle coordination: (writing, coloring, cutting, buttoning, etc.)

Is there any difficulty with drooling, chewing, sucking, swallowing, blowing bubbles?

Language and Speech: (please indicate age)

Random cooing, babbling of sounds:

First words:

Two-word combinations:

Three or more word combinations:

Was your child a/an (average, noisy, quiet) baby?

In your opinion, did speech and language skills develop normally?

Voice quality: (hoarseness, loss of voice, etc.)

Was there any difficulty understanding child's speech?

Behavioral Development: (hyperactivity, poor sleeping habits, tantrums, inappropriate behavior?)

Social and Emotional Development: (cooperative play, relationship with adults and children, reactions to school, new situation?)
