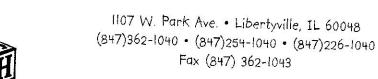


Building Block Pediatric Therapies of Illinois



Dear Parents:

Welcome to Building Block Pediatric Therapies of Illinois, LLC. We are so pleased that you have chosen us for your child's speech, occupational and physical therapy needs. We look forward to working with you and your child!!!

Attached you will find a "Patient Information Packet". Please fill out all the necessary information so our therapists can complete a comprehensive evaluation and/or therapy session for your child. Please return this packet prior to your child's appointment.

We will be happy to call your insurance company to verify benefits as well as bill the insurance company. However, you are also responsible for contacting your insurance company prior to your first visit in order to determine your benefits for speech/occupational/physical therapy. Any unpaid balances will become your responsibility.

Please contact us at (847)362-1040 or by e-mail at buildingblocktherapies@gmail.com if you have any questions. We look forward to meeting you!

Sincerely,

Laura Fowler Traci Micek



Pediatric Case History Form

Child's Name:Address:	Date of Birth
City, State, Zip:	
Who does child live with?	
Mother's Name:	
Mother's Occupation:	Work Phone:
Father's Name:	Work Phone:
Referred by:	
	Phone:
Pediatrician:Address:	Phone:
Siblings (names and ages):	
What is your child's primary language at home? Wat home?	
Why are you bringing your child in for an evaluatior condition etc.)	n? (Does not talk, has a diagnosed
When was the problem first noticed and by whom?	
Has your child received other interventions or service ntervention etc)	
Does anyone in your family have similar problems to Patient Medical Info	o those of the child?
Were there complications with this pregnancy?	YES/NO
Was the pregnancy full term?	YES/NO

If no, gestational a	age:					
	ength of Labor:					
Type of Delivery: Hea	d First In	duced		Cesarean		
Describe any unusual co			 			
Has your child been hosp	oitalized? It	f yes, plea	se explain: _			
				reason for medication		
Is your child allergic to ar	ything? Pl	ease list a		tion occurs:		
			₩ <u></u>			
Does your child have a history of ear infections?						
Feeding History:						
Is there a history of problems with sucking, swallowing or feeding? YES/NO If yes, please explain:						
Is there history of reflux?			YES/NO			
Does your child drink from Does your child drink from Does your child eat a vari explain:	a covered	cup?	YES/NO YES/NO our child avoi	d foods? Please		
Developmental History						
Speech and Language h	listory:					
Do you have concerns abo	out speech	and langu	age developr	nent? Please explain.		

How does your child communicate? (w	ords, sentences, gestures etc.)
Provide the approximate AGE at which	the child began to do the following:
Coo-	AGE
Babble-	
Use Single Words (no, dad, mom)-	
Combining Words- 2 words (no spoon,	Where mom?)-
Produce Sentences-	
Look in the Direction of Sound-	
Follow Simple Commands-	
Does your child interact with other children Same aged? Yes/No Younger? Yes/No Older Children? Yes/No Adults? Yes/No Is your child understood by familiar and the	en?unfamiliar listeners? Please explain
Gross Motor Development: Please indicate the AGES at which these	e milestones occurred:
Rolling-	Crawling-
Sitting-	Walking-
equire small or large muscle coordination	
Do you think your child is clumsy? Pleas	e explain:

Sensory/Fine Motor:

	ain:
Does	glue sand nail trimming water grass meat spinning_ tooth brushing_ hair cut_ climbing_swinging_ loud noises_ clothing tags
Does	your child seek out: rocking twirling spinning rough house jumping textures mouthing toys
Does	your child seem hyperactive or overly lazy?
	your child write, draw color? How does the child hold the tool?
	drinking from a cuppouring into a containerbathingtoiletingzippingbuttoningputting on clothestaking off clothes
<u>Educ.</u>	ational History:
Where	does your child attend school?
	the teacher have any concerns regarding your child's development?

has your child been diagnosed with a learning disability?	
Additional Information: Please provide any additional information that might be helpful:	
Person Completing Form:	
Relationship to Child:	
Signature: Date:	-36
Please return this packet prior to the evaluation. This can also be completed online. On the day of evaluation, you will need: *Insurance information	

Thank you for taking the time to fill out this important information. Thank you again for choosing Building Block Pediatric Therapies of Illinois, LLC.

*Prescription from the physician ordering the therapy/therapy evaluation

*Copy of any evaluations done by specialists

Please feel free to contact us at (847)362-1040 or buildingblocktherapies@gmail.com.