Building Block Pediatric Therapies of Illinois

1107 W. Park Ave. • Libertyville, IL 60048
(847)362-1040 • (847)254-1040 • (847)226-1040
Fax (847) 362-1043

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:_____ Date of Birth: _____
Address: _____ Phone: _____
City, State, Zip: _____

Who does child live with?_____

Mother's Name: _____
Mother's Occupation: _____ Work Phone: _____

Father's Name: _____
Father's Occupation: _____ Work Phone: _____

Referred by: _____ Phone: _____

Pediatrician: _____ Phone: _____
Address: _____

Siblings (names and ages): _____
_____

What is your child's primary language at home? What languages does your child speak at home?
_____

Why are you bringing your child in for an evaluation? (Does not talk, has a diagnosed condition
etc.) _____
_____
___

When was the problem first noticed and by whom?_____

Has your child received other interventions or services for the problem? (early intervention etc). _____

Does anyone in your family have similar problems to those of the child?

Patient Medical Information

Were there complications with this pregnancy? YES/NO

Was the pregnancy full term? YES/NO

If no, gestational age:_____

Length of Labor: _____ Birth Weight: _____

Type of Delivery: Head First Induced Breech Cesarean

Describe any unusual conditions that may have affected the pregnancy or birth?

_____

_____

Has your child been hospitalized? If yes, please explain: _____

_____

Is your child taking any medications? Please list name and reason for medication._____

_____

Is your child allergic to anything? Please list and what reaction occurs:_____

_____

Has your child had a hearing test? Results? _____

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 an open cup? YES/NO
Does your child drink from a covered cup? YES/NO
Does your child eat a variety of foods? Does your child avoid foods? Please explain:_____

_____

Developmental History

Speech and Language History:

Do you have concerns about speech and language development? Please explain.

_____

_____

_____

How does your child communicate? (words, sentences, gestures etc.)_____

_____

Provide the approximate AGE at which the child began to do the following:

	AGE
Coo-	
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 make and sustain eye contact? _____

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 unfamiliar listeners? Please explain._____

_____

Gross Motor Development:

Please indicate the AGES at which these milestones occurred:

Rolling-	Crawling-
Sitting-	Walking-

Does your child have difficulty walking, running or participating in other activities which require small or large muscle coordination?_____

Do you think your child is clumsy? Please explain: _____

_____

Sensory/Fine Motor:

Does your child require assistance with daily activities such as dressing, buttoning, feeding? Please explain: _____

_____

_____

Does your child dislike or overly sensitive to any of the following:

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?_____

Does your child write, draw color? How does the child hold the tool? _____

_____

Is your child right/left hand dominant? _____

Does your child have difficulty with:

____using utensils (fork, spoon)
___brushing teeth
___drinking from a cup
___pouring into a container
___bathing
___toileting
___zipping
___buttoning
___putting on clothes
___taking off clothes

Educational History:

Where does your child attend school? _____

If preschool, how many days/hours?_____

Does the teacher have any concerns regarding your child's development? (speech/language, social, fine motor etc) Please explain_____

_____

Is your child receiving special services? If so, please explain:_____

_____

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:_____

Please return this packet prior to the evaluation. This can also be completed online. On the day of evaluation, you will need:

*Insurance information
*Prescription from the physician ordering the therapy/therapy evaluation
*Copy of any evaluations done by specialists

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

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