Building Blocks Therapy Case History Form

CHILD INFORMATION

First Name | Middle Name | Last Name

Address | Age | Birth Date

City | State | Zip | Lives With | Nickname

FAMILY INFORMATION & HISTORY

Parent/Guardian Same As Child ☐

Name

Profession

Address | State | Zip

City

Home Phone

Work Phone

Cell Phone

Email Address

Parent/Guardian Same As Child ☐

Name

Profession

Address | State | Zip

City

Home Phone

Work Phone

Cell Phone

Email Address

Speech, language or learning-related difficulties (or family history of)

SIBLING INFORMATION

Name	Age	Related Difficulties

Other individuals living in the home

Other languages spoken in the home

BIRTH HISTORY

Describe your pregnancy and delivery:

Medications taken during pregnancy or during labor

Birthplace

Doctor

Labor Normal ☐ Induced ☐ C-Section ☐

Birth Weight

Length of Labor

Length of Hospital Stay

List Any Special Care or Precautions Taken During Pregnancy (Bed Rest, Oxygen, Jaundice, Etc.)

MEDICAL HISTORY

Pediatrician Telephone

Address

City State Zip

Date of last physical Results

Date of last hearing screening Results

Date of last vision screening Results

Vision Impairments Tubes in ears

Has your child ever been given a medical diagnosis? If so, what?

Allergies (please note reactions to allergies if applicable)

Current Medications

Please check all that apply:

Frequent colds ☐ Frequent respiratory infections ☐ Frequent ear infections ☐

Hearing Loss ☐ Chicken Pox ☐ Excessively high fever ☐ Mono ☐ Spinal Meningitis ☐

Epilepsy ☐ Cerebral Palsy ☐ Traumatic brain damage ☐ Seizures ☐

Other:

Please provide any information pertinent to checked items

Hospitalizations

Other professionals working with your child:

Name	Phone Number

MOTOR DEVELOPMENT

Note age of:

Sat Up Crawl Walk Jump (2 Foot) Potty Trained

Check if appropriate:

Trips or falls easily ☐ Afraid of climbing ☐ Clumsy ☐ Fear of Heights ☐ Difficulty grasping items ☐

FEEDING DEVELOPMENT

Note age of:

Breast-Fed | Drinking from a bottle | Drinking from a cup by self

Using utensils | Eating table food

Does your child have difficulties sucking, swallowing, chewing, drinking from a cup, drinking from a straw, eating different textures? (Explain)

Strong food preferences? | Avoids or dislikes certain foods | Allergies:

SPEECH AND LANGUAGE DEVELOPMENT

Note age of:

Babbling (bababa) | Jargon (linking babbling together) | First words | Combining words

Any time at which your child's speech and language or learning development regressed or ceased? (If yes, please explain)

Intelligibility of speech? (approximate) % to family | % to others

Please describe current concerns related to speech, language or learning development

Has the child had a speech and language evaluation previously? If yes, please note the place and findings.

Has the child had speech and language therapy in the past? If yes, please note the place and length of treatment

Is the child aware of difficulties he/she may be experiencing?

PSYCHOLOGICAL AND NEUROLOGICAL DEVELOPMENT

Has your child had a psychological evaluation? (If yes, please note reason, date and place and a brief summary of the results)

Has your child had a neurological evaluation? (If yes, please note reason, date and place and a brief summary of the results)

Check all that apply:

Nervous ☐ Hyperactive ☐ Sleepless ☐ Wets Bed ☐ Nightmares ☐ Sad ☐ Withdrawn ☐ Shy ☐

Easily Upset ☐ Destructive ☐ Aggressive ☐ Temper Tantrums ☐ Head Banging ☐ Swaying ☐

Tics ☐ Anxious ☐ Sensitive to sound in the environment ☐ Underreactive to sound in environment ☐

Short Attention Span ☐ Sensitive to being touched ☐ Underreactive to being touched ☐

Fearful of new situations, people, environment (excessively) ☐ Perseverative behaviors (does something over and over) ☐

EDUCATIONAL DEVELOPMENT

Current Grade

Teacher School

Previous schools attended

Specific concerns regarding school

Special services received at school

Special services received outside of school

Child's attitude toward school and learning new things

What are you hoping to gain/explore from evaluation or therapy?

Please note any concerns or related issues not covered in this case history

Who were you referred by?

Do you plan on filing for insurance reimbursement? Name of insurance company

Name of insured Policy or authorization number

We will not bill the insurance company directly, but can put this information on your bill to make the process easier for you.

It may also be helpful to keep a 2 day log of foods your child eats and bring this to your first appointment.

Preferred therapy days: Preferred therapy times:

Thank you for your time. Please print a copy of this form for your records.