Therapy for Language and Communication

Case History

Last Name: _____ First Name: _____ M.I. _____

D.O.B.: _____

Address: _____

Phone: (H) _____ (C)_____

Parent's Name: _____

Parent's e-mail: _____

How did you hear about TLC? _____

Physician: _____ Phone: _____

Insurance: _____ ID #: _____

Group: _____ Co-Payment: _____

Name of the insured: _____

Insured D.O.B.: _____ Insured employer: _____

Secondary Insurance: _____ ID# _____

Group: _____

Name of the insured: _____

Reason for visit:_____
What are the concerns you have? _____

What is your goal for therapy? _____

How does the individual react when there is a communication breakdown? _____

_____

How do you react when there is a communication breakdown? _____

_____

With whom does your child reside? (Please list residents and ages)
_____

Does your child have a medical conditions/diagnosis? Yes No

If yes, please explain: _____

Does he/she take any medications? Yes No

If yes, please list type, dosage, and frequency: _____

Gestation/labor delivery: _____weeks gestation _____lbs. ____oz.

Were there any complications during labor/delivery? Yes No

If yes, please explain: _____

Developmental Milestones:

Roll: _____ Sit Unsupported: _____ Crawl: _____

Walk: _____ First Words: _____ Sentences: _____

Has your child had prior therapy services? Yes No

What for? OT PT ST

Provider: _____ Duration: _____

Has your child's hearing been formally tested? Yes No

If yes, please provide where testing was performed, when, and results. _____
_____

Does your child have an IEP? Yes NO

If yes, what type of support services are in place, and at what frequency are services implemented?

_____

If your child is not school age, what child care services do you have established? (Please list placement, as well as frequency and duration of child care.)

_____

What is your child's attention for self-directed activities? _____

What is your child's attention for other-directed activities? _____

What are you child's areas of interest?_____