St. Luke's Pediatric Rehabilitation
Evaluation Appointment

Prior to your evaluation appointment, please make sure that you have completed the following:

1. Complete the enclosed Case History Form and return within 30 days.

2. Check into your insurance coverage for each necessary therapy. Please make sure that you ask if there are exceptions or limitations under your current policy.

3. Obtain any previous evaluation/therapy reports. If your child has been to any specialists, those reports would be beneficial as well. It is important that the therapist has all pertinent reports prior to the evaluation. Documents may be sent directly to St. Luke's North from physicians, hospitals, or therapists. For example, the following records would be helpful: IU/EI evaluations, discharges, treatment notes; developmental pediatrician reports, psychological or behavior reports, etc.

4. Contact your physician and obtain a prescription/order from your physician for the evaluation and subsequent treatment.

5. When you are called with an evaluation appointment date, call your insurance company to obtain a referral form or pre-authorization form (if required by your insurance company).

Thank you in advance for your cooperation. If you have any questions regarding the above requests, please call us at 484-526-3200.

Pediatric Rehabilitation
St. Luke's North
153 Brodhead Road
Bethlehem, PA 18017

CASE HISTORY

***** All information on this form is considered confidential!***

Child's Name: ______________________________ Date: ______________

DOB: ______________ Age: _____ Sex: ☐ Female ☐ Male

Address: ____

City: ______________________ State: ________ Zip Code: ______________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone(s): ____________________ Preferred contact number: ☐ Home ☐ Cell ☐ Work

Person completing form: ________________ Relationship to patient: ________________

PARENT INFORMATION:

Father: ______________________ Age: ____ Occupation: ______________

Mother: ______________________ Age: _____ Occupation: ______________

BACKGROUND INFORMATION:

Other adults in the home and their relationship to the child: ______________________

____

Language(s) spoken in the home other than English: ______________________

If other languages are spoken, which did your child learn first?: ______________________

If in school, what type of programing is your child receiving?: Please explain -

- ☐ Regular Education: ______________________
- ☐ Special Education: ______________________
- ☐ E.S.L. Support: ______________________
- ☐ Bilingual Ed: ______________________
- ☐ Primary Language Instruction: ______________________

If receiving other therapies: What type: ______________________

Where: ______________________ When: ______________________

Any other specialty services (i.e., TSS, etc.): ______________________

____

Primary care physician or pediatrician: ____________________ Phone: ______________

Address: ____

Who referred you to this facility? ______________________

Reason for referral: ____

What concerns do you or family members have about this child?:___________________________

____

____

____

BIRTH HISTORY:

Length of pregnancy: _______________ Did mother smoke? ☐Yes ☐No Drink?: ☐Yes ☐No

What medications did birth mother receive? ____

____

Describe any problems during the pregnancy? ____

____

____

Birthweight: _____lb. ____oz. Length: ______ inches

Duration of labor: _________________ Anesthesia used: _________________________________

Hospital: __________________________________ Physician: ____________________________

Type of delivery: ☐ Vaginal ☐Casearean

Any labor or birth complications (i.e. baby's position, cord around neck, breathing difficulties)?

Explain: ____

____

____

Did mother receive blood during or after delivery? ☐Yes ☐No Did child?: ☐Yes ☐No

Did baby need oxygen?: ☐Yes ☐No Was baby in ☐ regular nursery ☐Special care nursery

Was baby placed in incubator: ☐Yes ☐No Duration of baby's hospital stay________________

Any other pertinent birth information ____

____

____

DEVELOPMENTAL HISTORY:

Any current or past difficulties with ☐ sucking ☐ swallowing ☐chewing? Please describe:

____

Note the AGE at which your child accomplished the following:

Held head up:______ Rolled over: ______ Sat without support:_____

Crawled: ______ Stood alone: ______ Walked alone: _____

Toilet trained: ______ Any other problems?__________________________________

Describe your child's attention span: ____

____

How does your child get along with other children?:_______________________________

____

MEDICAL HISTORY:

History of disease (e.g. colds, earaches, bronchitis, high fevers, convulsions)

Type of Illness	Date	Severity	Temperature

Describe any hospitalizations/surgeries:____

____

____

Has your child ever received oxygen? ☐Yes ☐No Why? __________________________

____

Any allergies? ☐Yes ☐No If yes, describe: _________________________________

____

Has your child had any of the following conditions:

- ☐ Motor difficulties
- ☐ Temper tantrums
- ☐ Head banging
- ☐ Staring spells
- ☐ Physical weakness
- ☐ Seizures
- ☐ Ear infections
- ☐ Drooling

Has your child had his/her hearing screened? ☐Yes ☐No

If yes, Where? ___________________________ When? ________________________

Results: ____

Has your child had his/her vision screened? ☐Yes ☐No

If yes, Where? ___________________________ When? ________________________

Results: ____

Has your child been seen by any other specialist? ☐Yes ☐No If yes, Please explain: _______

____

____

Is your child currently on any medications?: ☐Yes ☐No Please list:___________________

____

FAMILY BACKGROUND:

Names of other children in the family

Name	Age	Grade in School	Living at Home

Has anyone in your family needed special education services or therapies? ___________________

____

____

EMERGENCY CONTACT INFORMATION:

Name:______________________________ Relationship:_____________Phone:_________________

Name:______________________________ Relationship:_____________Phone:_________________

INSURANCE INFORMATION:

Primary Insurance Carrier: ____

Policy Number:___________________________ ID/Group Number:_____________________

Subscriber Name: ________________________Employer:_____________________________

Secondary Insurance Carrier:____

Policy Number:___________________________ ID/Group Number:_____________________

Subscriber Name: ________________________Employer:_____________________________

CHILD'S CURRENT SCHEDULE/AVAILABILITY: (I.E., DAYS/TIMES IN SCHOOL, OTHER THERAPY)

____

____

____

____

____

____

***** PLEASE BE ADVISED THAT *AFTER SCHOOL TIMES* OFTEN REQUIRE A LONGER WAITING TIME.**

YOUR FLEXIBILITY WILL ASSIST OUR THERAPISTS IN PROVIDING SERVICES FOR YOUR CHILD. ***

Occupational Therapy

If you are seeking occupational therapy for your child, please complete this section.

Play Skills:

What does your child like to play with? ____

____

What does your child dislike playing with? ____

____

Describe your child's attention to structured/unstructured play: __________________________

____

____

How does your child spend unstructured time? _______________________________________

____

Describe your child's social behavior with others: _____________________________________

____

Self Help:

Has your child ever used feeding utensils? ☐Yes ☐No If *yes*, is assistance needed for success? Please describe: ____

____

How much assistance is needed (if any) with self dressing? ______________________________

____

Can your child complete buttons, zippers, snaps? ☐ Yes ☐ No

Can your child independently drink from a cup? ☐ Yes ☐ No

Physical Therapy

If you are seeking physical therapy for your child, please complete this section.

Has or does the child use braces or orthotics?____________________________________

____

Has or does the child use any assistive devices? _________________________________

____

Has the child seen an orthopedic doctor? ☐ Yes ☐ No If so, who?_______________

When?___________ Why?____

SPEECH-LANGUAGE THERAPY

IF YOU ARE SEEKING SPEECH-LANGUAGE THERAPY FOR YOUR CHILD, PLEASE COMPLETE THIS SECTION.

HEARING

Has your child's hearing appeared normal? ☐ Yes ☐ No

If no, describe: ____

Does he/she respond to soft or moderate sounds? ________________________________

Does he/she seem to listen to people's voices? ___________________________________

Can he/she follow instructions which are expected for his/her age? __________________

____

Does he/she like to listen to children's stories? __________________________________

Other comments: ____

SPEECH AND LANGUAGE

PLEASE PROVIDE AGE AND EXAMPLE FOR THE BELOW CATEGORIES

Age: Example:

1. Babbling____
2. First words____
3. Put 2 words together ____
4. Put 3-4 words together ____
5. Sentences ____

Has the speech progress ever been interrupted or reversed? If so, please describe

____

____

When was the problem with speech/language first noticed? __________________________

Did it follow an illness, accident or unusual occurrence? ____________________________

If so, please describe____

____

In your own words, please describe your child's speech/language problem______________

____

____

____

Does the family understand his/her speech most of the time?_________________________

Do people outside the family?:____

Does anyone in your family have a history of speech/language difficulties?_____________

____

Thank you!