**Child's Name** *

laskin therapy group

## CASE HISTORY FORM

Laskin Therapy Group requests this information for the sole purpose of completing your child's evaluation.
Completion of this form is a part of the evaluation process and assists us in determining our recommendations for your child.

### GENERAL INFORMATION

| **CHILD'S NAME:** | **DATE OF BIRTH:** | **AGE:** |
|---|---|---|
| PERSON PROVIDING THE INFORMATION: | TODAY'S DATE: | SEX: |
| **ARE YOU THIS CHILD'S LEGAL GUARDIAN?** Y ☐ N ☐ | **ONLY LEGAL GUARDIAN CAN SIGN ALL PAPERWORK** | |
| RELATION TO CHILD: | REFERRED BY: | |
| E-MAIL ADDRESS: | CHILD'S PHYSICIAN: | |
| CHILD'S ADDRESS: | CHILD'S SOCIAL SECURITY #: | |
| **INSURANCE NAME :** | **SECONDARY INSURANCE NAME:** | |
| MOTHER'S NAME: | FATHER'S NAME: | |
| MOTHER'S HOME NUMBER: | FATHER'S HOME NUMBER: | |
| MOTHER'S CELL NUMBER: | FATHER'S CELL NUMBER: | |
| MOTHER'S WORK NUMBER: | FATHER'S WORK NUMBER: | |
| **EMERGENCY CONTACT:** NAME: | RELATIONSHIP: | |
| HOME PHONE: CELL PHONE: | WORK NUMBER: | |

The family requests that results of this evaluation should be sent to:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Please complete consent/release form to allow us to do this.

Please describe the reason(s) for evaluation/your main concerns:

- ☐ Fine Motor (use of hands for: dressing, handwriting, play feeding/eating)
- ☐ Gross Motor (crawling, walking, jumping, running, climbing)
- ☐ Speech (If checked, please be specific about your concern)
- ☐ Language (If checked, please be specific about your concerns)
- ☐ Sensory Integration (If checked, please explain)
- ☐ Mobility (If checked, please explain)
- ☐ Feeding/Picky eater (If checked, please explain)
- ☐ Behavior (If checked, please explain)
- ☐ Other concerns (please explain)

Please list any diagnosis, who diagnosed your child and when was diagnosed:

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Has your child had any other testing and/or therapy in the following areas?
If so, please list types and dates of testing and who/where completed the testing:

☐ educational _____

☐ speech/language _____

☐ occupational therapy _____

☐ physical therapy _____

☐ psychological _____

Does your child currently have or has ever had any of the following equipment? ☐ wheelchair ☐ power ☐ manual ☐ braces ☐ walker/gait trainer ☐ crutches/ cane/specialized utensils ☐ reacher ☐ positioning equipment ☐ hand rail ☐ other

**FAMILY HISTORY**

| | | |
|---|---|---|
| Father's Name: | Age: | Occupation: |
| Mother's Name: | Age: | Occupation: |
| Is child adopted? ☐ **Yes** ☐ **No** If so, at what age? | | From where/what country? |
| Marital status of parents (check one): ☐ Married ☐ Living together ☐ Separated ☐ Divorced ☐ Other | | |
| Who lives in the house with this child? (If children are listed, please give names, ages, and relationship.) | | |
| Are any languages other than English spoken at home? **Yes** ☐ **No** ☐ If yes, which one(s)? | | |
| Home Environment: ☐ 1 story home ☐ 2 story home ☐ steps to enter; ☐ steps with handrail OR ☐ no handrail | | |
| Please indicate if there have been any instances of the following in your immediate or extended family members: Psychological, educational/cognitive, speech/language, stuttering, occupational or physical problems, ADHD, learning disabilities, Autism spectrum, or hearing loss. Also please share how those individuals are related to the child and any therapy they have received: | | |

**PREGNACY AND BIRTH HISTORY**

| | | |
|---|---|---|
| 1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Please describe: | **Y** ☐ | **N** ☐ |
| 2. Was this pregnancy full-term? If not, please give gestational age at time of delivery. | **Y** ☐ | **N** ☐ |
| 3. Were any drugs or medications taken during this pregnancy? If so, please specify: | **Y** ☐ | **N** ☐ |
| 4. Were labor and delivery normal? If not, please explain. | **Y** ☐ | **N** ☐ |
| 5. Please list birth weight and length: Weight Length | | |
| 6. Was the delivery vaginal, breech, or caesarian? ☐ Vaginal ☐ Breach ☐ Caesarian | | |
| 7. Were forceps/suction used? | **Y** ☐ | **N** ☐ |
| 8. Did your child experience jaundice? | **Y** ☐ | **N** ☐ |

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| | | |
|---|---|---|
| 9. Was there a need for oxygen or respiratory assistance? | Y ☐ | N ☐ |
| 10. Were there difficulties with feeding? If so, please explain: | Y ☐ | N ☐ |
| 11. Did your child bottle-feed, breast feed, or both? ☐ Breast ☐ Bottle ☐ Both | | |
| 12. Did your child have difficulties sucking? | Y ☐ | N ☐ |
| 13. Are there any issues with sleep patterns? If so, please explain. | Y ☐ | N ☐ |
| 14. Number of siblings: | | |
| 15. Which pregnancy was this child? | | |

**MEDICAL HISTORY**

| 16. Has your child had any of the following illnesses/disorders?: | Yes | No |
|---|---|---|
| a. Meningitis | ☐ | ☐ |
| b. Seizures | ☐ | ☐ |
| c. Frequent Ear Infections | ☐ | ☐ |
| d. Did/Does your child have P.E. tubes? If yes, when and are they still in? | ☐ | ☐ |
| e. Does your child have a hearing loss? If yes, please explain. | ☐ | ☐ |
| f. Has your child had his/her hearing tested? If so, when and what were the results? | ☐ | ☐ |
| g. Experience(d) excessive vomiting or reflux. Does/did your child exhibit irritability/fussiness following during feedings? If yes, please describe: | ☐ | ☐ |
| h. Are there any current or previous feeding or swallowing difficulties/concerns? If yes, please describe: | ☐ | ☐ |
| i. Cleft Lip/Palate? If yes, please describe: | ☐ | ☐ |
| j. Does your child have vision problems? If yes, please describe: | ☐ | ☐ |
| k. Is your child on any medications? Please list current and past: | ☐ | ☐ |
| l. Please describe any pertinent medical conditions not mentioned above. (ie, accidents, injuries…) | | |
| m. When was your child's most recent hospitalization? (Please explain/describe): | | |

**GROWTH AND DEVELOPMENT (answer as best remembered)**

| 17. What age did your child: | AGE | COMMENTS |
|---|---|---|
| a. roll over from stomach to back? | | |
| b. roll from back to stomach? | | |
| c. sit independently? | | |
| d. crawl? | | |

| | | |
|---|---|---|
| e. cruise around furniture? | | |
| f. walk independently? | | |
| g. speak first word? | | |
| h. speak 2 word sentences? | | |
| i. drink from a cup? | | |
| j. use a spoon? | | |
| k. dress independently? | | |
| l. toilet trained? | | |
| m. toilet trained through the night? | | |
| n. Estimate how many words are in your child's expressive (speaking) vocabulary. | ☐ < 25 ☐ 15-75 ☐ >75 | |
| o. Estimate how many words are in your child's receptive (words they understand) vocabulary. | ☐ < 25 ☐ 15-75 ☐ >75 | |

| 18. Describe your child by answering yes or no to the following: | Yes | No |
|---|---|---|
| a. Mostly quiet? | ☐ | ☐ |
| b. Overly active/restless? | ☐ | ☐ |
| c. Tires easily? | ☐ | ☐ |
| d. Talks constantly? | ☐ | ☐ |
| e. Impulsive? | ☐ | ☐ |
| f. Stubborn? | ☐ | ☐ |
| g. Resistant to changes/difficulty transitioning between activities? | ☐ | ☐ |
| h. Over reacts? | ☐ | ☐ |
| i. Fights frequently? | ☐ | ☐ |
| j. Usually happy? | ☐ | ☐ |
| k. Has frequent temper tantrums? | ☐ | ☐ |
| l. Clumsy? | ☐ | ☐ |
| m. Has nervous habits or tics? | ☐ | ☐ |
| n. Has poor attention span? | ☐ | ☐ |
| o. Frustrated easily? | ☐ | ☐ |
| p. Has unusual fears? If yes, please describe: | ☐ | ☐ |
| q. Rocks self frequently? | ☐ | ☐ |
| r. Exhibits difficulty learning new tasks? | ☐ | ☐ |
| s. Avoids touch? | ☐ | ☐ |
| t. Craves touch, seeks it out? | ☐ | ☐ |
| u. Shy? | ☐ | ☐ |
| v. Compliant? | ☐ | ☐ |

**SOCIAL/EMOTIONAL DEVELOPMENT**

| 19. Describe your child by answering yes or no to the following: | Yes | No |
|---|---|---|
| a. Is your child easily managed at home? Who manages him/her? | ☐ | ☐ |
| b. Does your child empathize with others' feelings (happy, sad, angry…)? | ☐ | ☐ |
| c. Does your child understand punishment and does he/she show remorse? | ☐ | ☐ |
| d. Does your child understand praise and reward? | ☐ | ☐ |

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| | | |
|---|---|---|
| e. Does your child recognize danger (climbing on ladders, onto cabinets…)? | ☐ | ☐ |
| f. Does your child show concern when separated from parents? | ☐ | ☐ |
| g. Does your child have friends? | ☐ | ☐ |
| h. How does your child like to spend their free time? | | |

**COMMUNICATION HISTORY**

| | | |
|---|---|---|
| 20. How does your child communicate at home & school? (ie: verbal, sign, augmentative/alternative communication device…) | | |
| 21. Can your child: | | |
| a. understand and follow simple directions? | ☐ | ☐ |
| b. identify body parts? | ☐ | ☐ |
| c. recognize pictures of common objects? | ☐ | ☐ |
| d. turn his/her head when name is called? | ☐ | ☐ |
| e. communicate with intent? | ☐ | ☐ |
| f. answer "wh" questions? | ☐ | ☐ |
| g. Please describe any communication difficulties and tell us at what age this was first noticed | | |

**OCCUPATIONAL PROFILE**

| 22. **Ages 1-3, Does your child:** | Yes | No |
|---|---|---|
| a. Show interest in playing with blocks? | ☐ | ☐ |
| b. Draw lines, dots, and circles with a crayon? | ☐ | ☐ |
| c. Imitate simple gestures that you make? | ☐ | ☐ |
| d. Engage in back and forth ball play? | ☐ | ☐ |
| e. Use one hand more often than another? | ☐ | ☐ |
| f. Unbutton large buttons (2+ years)? | ☐ | ☐ |
| g. Identify 1-6 body parts on self? How many? | ☐ | ☐ |
| h. Grasp pencil or crayon with thumb and fingers instead of fist? (3 years) | ☐ | ☐ |
| 23. **Ages 4-5, Does your child:** | ☐ | ☐ |
| a. Enjoy finger painting, play-doh, and sandbox activities? | ☐ | ☐ |
| b. Attempt to color a picture vs spontaneously scribble across page? | ☐ | ☐ |
| c. Have experience using scissors to snip paper? | ☐ | ☐ |
| d. Button and unbutton on self? | ☐ | ☐ |
| e. Use a pencil grasp that resembles an adult's pencil grasp? | ☐ | ☐ |
| 24. **Ages 5 and up:** Describe any problems with dressing handwriting, self-care, play skills, hand strength/general Weakness, coordination, attention, etc. : | | |

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**EDUCATIONAL BACKGROUND**

| | | |
|---|---|---|
| 25a. Does your child attend school? If so, where? What grade? | Y ☐ | N ☐ |
| b. Does your child receive special education or therapies in school? If so, please give details. (OT, PT, Speech, frequency, length of sessions, individual/group.) | Y ☐ | N ☐ |
| c. If applicable please list school therapists' names/phone numbers and provide a copy of his/her current IEP. | | |
| d. If needed, may we communicate with school staff? (please complete "Consent Form") | Y ☐ | N ☐ |

## ***The following 2 sections must be completed before evaluation begins:***

Please note that by typing your name in the spaces below you are providing consent for billing and services.

**THERAPY PRECAUTIONS (Please be specific and please answer both questions.)**

| | | |
|---|---|---|
| **Does your child have any food allergies? Your initials:** If yes, please list and discuss with the therapist **in detail** | Y ☐ | N ☐ |
| **Are there any precautions not listed above that we should know about? Your initials:** If yes, please list and discuss with the therapist in detail. | Y ☐ | N ☐ |

**Laskin Therapy Group** does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities or in employment. For further information about this policy, contact Rebecca D. Laskin at 601-362-0859 extension 111.

- I hereby consent for the use or disclosure of my child's protected health information (PHI) to carry out treatment, payment or healthcare operations. This includes assignment of benefits when applicable.
- I have received and read a copy of the Notice of Privacy Practices for **Laskin Therapy Group** and understand its meaning.
- I understand that I have the right to request that this provider restrict how PHI is used or disclosed to carry out treatment, payment or healthcare operations, and that the provider is not required to accept the requested restrictions.
- I have the right to revoke the consent, in writing, except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

I also authorize a licensed therapist to provide therapy services for my child as the need is indicated by his/her attending physician. I furthermore authorize the Physical, Occupational, and Speech/Language therapy staff of **Laskin Therapy Group** to screen and/or evaluate the above named patient.

List requested restrictions:

Specific description of information to be restricted including date(s):

(Signature of child's representative) (Printed name of child's representative)

Relationship to Child Date

**Child's Name** *

**For Medicaid/CHIP Recipients Only:**
I request that payment of authorized Medicaid/CHIP benefits be made on behalf of my child to LASKIN THERAPY GROUP. I authorize medical or other information about my child to release to the Division of Medicaid, or the fiscal agent, any information needed to determine benefits. This authorization is for my lifetime.

(Signature of child's representative) (Date)

As required by the Division of Medicaid to coordinate school and outpatient therapy services, this letter serves as written certification that services for will be coordinated between School and Laskin Therapy Group (LTG) or are only received at Laskin Therapy Group. (Please mark the appropriate box).

☐ Services will be coordinated between the School District and Laskin Therapy Group

☐ Services are **ONLY** received at LTG; my child does **NOT** receive therapy at his/her school.

(Signature of child's representative) (Date)

SIGN THIS SECTION IF CHILD HAS **ONLY** A FORM OF MEDICAID OR CHIP

**My child only has Mississippi Medicaid, Medicaid's MississippiCan United HealthCare, or Magnolia HealthPlan. My child has no other form of medical insurance.**

(Signature of child's representative) (Date

**OR SIGN THIS SECTION IF YOU HAVE TWO INSURANCES - MEDICAID AND AN ADDITIONAL INSURANCE POLICY**

** List the insurances the child is covered on:
Example: BCBS of MS **EX**
Medicaid **EX**
(*Medicaid will always be secondary)

Primary Insurance Initial
Secondary Insurance Initial

MS Division of Medicaid requires that when a child has commercial insurance, that insurance is considered primary and must be filed before Medicaid, therefore, if your child is covered under both a primary insurance (such as BCBS, Cigna, etc) and MS Medicaid, we will file your commercial insurance first. Then after the commercial insurance has processed, we will file the Medicaid. Your child's services will not cost you anything out of pocket.

If you have primary and secondary insurances, all payments go to Laskin Therapy Group. If a payment is sent to you or the subscriber by mistake, it must be signed by the individual the check was written out to, or if it was written out to the child, it must be signed by the parent or legal guardian and turned over to Laskin Therapy Group.

By signing below, you are stating that all of the information given is true and these are the only insurances covering your child. Also, by signing here you indicate that you understand any insurance payments made to you or the subscriber belong to Laskin Therapy Group and must be turned over to Laskin Therapy Group.

(Signature of child's representative) (Date)