APEX PEDIATRIC THERAPY SERVICES

Phone: (847) 376 9191; Fax: (847) 589 5875
info@apexped.com; www.apexped.com

CHILD'S INFORMATION REPORT

THIS FORM MUST BE FILLED IN COMPLETELY

Background Information

Date_____

Child's Name (First)_____(MI) ____(Last) _____

Address_____ City_____ State_____

Zip_____

Date of Birth _____/_____/_____ Gender __F __M

Name of Parent/Guardian (Primary)_____

Telephone (Home)_____(Work)_____(Cell)_____

Email_____ Preferred method of contact:_____ email _____phone

Name of Parent/Guardian (Secondary)_____

Telephone (Home)_____(Work)_____(Cell)_____

Email_____ Preferred method of contact:_____ email _____phone

Referring Agency: _____Case Worker:_____

Number of Hours Approved through DHS: _____

Name of School/Day Program: _____

Teacher:_____QSP/QMRP:_____

Emergency Contact Information

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In case of emergency, contact:

Name (1) _____ Relationship_____Phone_____

Address_____ City_____ State_____Zip_____

Name (2) _____ Relationship_____ Phone_____

Address_____ City_____ State_____Zip_____

Primary Care Physician

Does the child have a Primary Care Physician (PCP) (Y/N only)? _____

Will the parent(s) be open to us sharing the child's progress report with the PCP? Please provide your consent (Y/N only)? _____

Medical History

Current Diagnosis_____

Please list medications and dosages currently taken:

MEDICATION	DOSAGE

Name pf prescribing doctor: _____ Professional Licensure/Credential: _____

Sleep issues related to ASD ___Yes ___No
If yes, please describe _____

Eating issues related to ASD _____Yes _____No

If yes, please describe _____

Medical Conditions_____

_____

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Known Allergies_____

_____

Physical Handicaps_____

_____

Please describe any prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic)

_____

_____

_____

_____

Please describe if there is any behavioral or medical family history that might have impacted the consumer's behavior, speech or occupational.

_____

_____

Please discuss if there are any relevant legal issues in the family that might have had an impact on child's behavior that we should be aware of.

_____

_____

History of Therapy

Has the child had ABA, Speech or Occupational services with any other provider? ___No __Yes

When was the initial date? _____

Intensity of these services: ___Focused ____Comprehensive

Avg. # of hours/week _____

Continuous ABA/Speech/Occupational services since start? ___Yes ____No

If break from services, when and why?

Current Therapy

Please let us know if the child is currently being seen by another behavioral/speech/occupational health clinician.
(Y or N Only) _____

If the child is being seen by another health clinician, do you give us consent to discuss and release information to the other behavioral health clinician if need for collaboration arises (Y/N only)?
_____

Supports Outside ABA/Speech/Occupational Treatment

Child accessing other school program? ___Public ___Private ____Home

Other (Specify)_____

Child has IEP, ISP, 504 or ARD in place? ____Yes ____No If no, why not?

Is Child accessing other therapeutic services?

____Physical Therapy ____Occupational ___Speech ____NA

Is there coordination of care with other medical or BH providers? ____Yes ____No;

Those are _____

Is the family accessing community supports? ____Yes _____No Which ones _____

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Child's Needs

Please describe in detail the reasons for seeking behavior/speech/occupational therapy. (What is the underlying problem, if any?) _____

_____

_____

_____

_____

_____

_____

How does he/she communicate? (check all that apply)

Gestures____ PECS_____ Signing____ Verbal Utterance (sound)_____ Speech____

He/She understands: (check all that apply)

Gestures____ Signing____ Verbal Utterance (sound)_____ Speech____

What are some objects/activities/foods he/she LIKES?_____

_____

_____

_____

_____

What are some objects/activities/foods he/she DISLIKES?_____

_____

_____

_____

_____

What are his/her strengths?_____

_____

_____

_____

_____

What are your expectations from therapy? On what would you like to see your loved one improve?

_____

_____

Does he/she prefer to be around children or adults? Children_____ Adults_____

Describe how he/she interacts with those in his/her own age group: _____

Describe any problems that are occurring at school/day program: _____

Can he/she use the restroom independently? Yes____ No___

Are there any cats/dogs in your home? Yes____ No___

Parent/Guardian Signature_____ Date_____

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE ALONG WITH A COPY OF THE CHILD'S:

COMMERCIAL INSURANCE COPY / MEDICAID CARD
PSYCHOLOGICAL EVALUATION (if applicable)
IEP (if applicable)
OTHER RELEVANT EVALUATIONS