CASE HISTORY

PERSONAL INFORMATION

Child Name:	Gender: ☐ Male ☐ Female	DOB:	Age:
Address: (Street, City, State, Zip Code)		Diagnosis/Problem:	
Parent/Caregiver Name(s):		Relationship to Patient:	
Home Phone #:	Cell Phone #:	Work Phone #:	E-Mail Address:
Emergency Contact: (Different From Above)		Relationship to Patient:	
Home Phone #:	Cell Phone #:	Work Phone #:	E-Mail Address:

PREGNANCY & DELIVERY HISTORY

QUESTION	ANSWER	DETAILS
Was prenatal care received?	Yes	If YES, what month was it initiated?
Were there medical concerns prior to/during pregnancy?	Yes	If YES, please explain in detail:
Were there emotional concerns prior to/during pregnancy?	Yes	If YES, please explain in detail:
Did you have a premature pregnancy (less than 37 weeks)?	Yes	If YES, at how many weeks was the child born?
Did you have any complications at birth?	Yes	If YES, please explain in detail:
Were any of the following present at birth: Jaundice, breathing difficulties, feeding difficulties, NICU?	Yes	If YES, please write which ones:
Is your child adopted?	Yes	If YES, when was s/he adopted? If YES, where is s/he adopted from?
Do you know any birth history or orphanage details?	Yes	If YES, please explain:
Does your child know he/she is adopted?	Yes	

Please describe IN DETAIL the labor and birth of your child (weight, form of delivery, complications, postnatal care):

DEVELOPMENTAL HISTORY

Please indicate at what age your child began:

SKILL	AGE	DETAILS
• Roll over		
• Crawl		
• Sitting		
• Pull to stand		
• Reach for toy		
• Walk		
• Isolate fingers to count		
• Breast feed		
• Bottle feed		
• Eat finger foods		
• Drinks from an open cup		
• Drinks from a straw		
• Uses a spoon/fork		
• Babbles		
• Say first words		
• Pair two words		
• Recognize familiar faces/voices		
• How many words total:		

SURGICAL HISTORY

Please list all surgeries and hospitalizations your child has had.

Surgeries/Hospitalizations:	Date:	MD/Surgeon:	Condition/Details:

MEDICAL HISTORY

Please check "√" all that apply.

☐ Acid Reflux	☐ Cerebral Palsy	☐ HIV/AIDS	☐ Swallowing Problems
☐ ADD/ADHD	☐ Cyanosis	☐ Jaundice	☐ Torticollis
☐ Anoxia	☐ Cytomegalovirus	☐ Juvenile Arthritis	☐ Traumatic Brain Injury
☐ Allergies:_____	☐ Down Syndrome	☐ Plagiocephaly	☐ Visual Problems
☐ Asthma	☐ Ear Infections/Tubes	☐ Pneumonia	☐ Other:
☐ Autism/PDD	☐ Headaches	☐ Prematurity	☐ Other:
☐ Balance Problems	☐ Heart Problems	☐ Seizure/Epilepsy	☐ Other:
☐ Cancer	☐ Hepatitis	☐ Speech/Lang Problems	

Is there any of the above medical history in the immediate family? ☐ Yes ☐ No
If yes, explain:

Has your circle seen any of the following specialist(s):
☐ Cardiologist ☐ Neurologist ☐ Orthopedist ☐ Optometrist/Ophthalmologist
☐ Psychologist/Psychiatrist ☐ Developmental Pediatrician

MEDICATION HISTORY

Please list current medications, dosage and the condition the medication is treating.

Medication	Dosage	Condition

INTERVENTION HISTORY

Please list the names of any specialists that have evaluated your child, date of the evaluation & any diagnoses.

Specialist Name	Date of Evaluation	Diagnoses

HEARING/AUDIOLOGY HISTORY

Has your child every received a hearing screen or a formal evaluation to test their hearing? ☐ **YES** ☐ **NO**

When:	Date:	Results: ☐ Negative ☐ Positive

FAMILY/SOCIAL HISTORY

Please list the names, ages and relation of those living in your home.

Name	Age	Relationship to child

My child's primary care giver is:

What kind, if any, outside play area does your child have access to:

Does your child have his/her own bedroom or share?

My child's sleeping habits: (location & hours)

Is your child a picky eater? If yes, please explain (ie. aversions to textures and/or smells):

Describe any significant changes your child has experienced in the past 3 months:

Are there any religious, spiritual, or ethnic customs your therapist should be aware of? Please describe:

My child's strengths are:

Please describe your child's play skills:

SELF CARE SKILLS

Use the drop down to chose the "%" level that indicates the level of independence your child demonstrates with the following skills.

• Brushing teeth	-
• Bathing	-
• Dressing	-
• Toileting	-
• Self feeds	-
• Use of utensils	-
• Sippy cup	-
• Open cup	-
• Straw drinking	-
• Sits for meals	-
• Organizes homework	-
• Answers basic questions about self (name & age)	-
• Recognizes printed name	-
• Asks for help	-

SCHOOL/DAY CARE HISTORY

Name of my child's current School/Day Care:

My child's current grade/placement:

My child's current Teacher(s) Name(s):

Do I have permission to contact your child's school teacher/therapists? (phone#/email)

My child's current School Therapist(s) Name(s):

My child receives the following support services (ie. Physical, occupational, speech therapy) at school:

My concerns surrounding my child and her/his school:

What other information can you tell me about your child?
What questions do you have regarding therapy and your child?
What do you hope we can accomplish in therapy?

Thank you for your assistance in completing this form. This information is confidential and will be used strictly for therapeutic purposes.

_____ _____

Name of person completing this form Relationship to the child

_____ _____

Signature of person completing this form Date