

Children's Therapy Center, INC

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CHILD CASE HISTORY FORM

Children's Therapy Center, INC requests this information for the sole purpose of completing your evaluation. Completion of this form is required prior to your scheduled evaluation. Failure to provide the required information will result in an incomplete examination or cancellation of the assessment.

GENERAL INFORMATION

CHILD'S NAME:	Date of Birth:	AGE:
Person Providing the Information:	Today's Date:	SEX:
CHILD'S ADDRESS:	REFERRED BY:	
TELEPHONE NUMBER: CELL PHONE NUMBER:	PHYSICIAN:	
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 for evaluation/main concerns:

- Fine Motor
- Gross Motor
- Speech
- Language
- Sensory
- Mobility
- Feeding
- Behavior

Other concerns/please explain: _____

Which services are you requesting?

- Occupational Therapy
- Speech Therapy
- Physical Therapy

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

THERAPY PRECAUTIONS-Please be specific

Does your child have any food allergies or any other allergies you are aware of? Please list.	YES	NO	
If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?	Y	N	
Are there any precautions not listed above that we should know about. Please describe. (latex allergies, dietary restrictions...)	Y	N	

FAMILY HISTORY

Father's Name:	Age:	Occupation:			
Mother's Name:	Age:	Occupation:			
Is client adopted?	If so, at what age, and from where/what country?				
Are parents (circle one):	Married	Living together	Separated	Divorced	Remarried
Who lives in the house with this child, other than the parents? (If children are listed, please give names and ages)					
Have there been any instances of the following in your immediate or extended family members:					
<input type="radio"/> ADHD	<input type="radio"/> Learning Disabilities	<input type="radio"/> Communication Disorders	<input type="radio"/> Autism/PDD	<input type="radio"/> Hearing Loss	<input type="radio"/> Stuttering

PREGNANCY AND BIRTH HISTORY

	YES	NO	COMMENTS
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe.	Y	N	
2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery.	Y	N	
3. Were any drugs or medications taken during this pregnancy? If so, please specify.	Y	N	
4. Was labor and delivery normal?	Y	N	
5. Please list birth weight and length.			
6. Was the delivery vaginal, breech, or caesarian? Were forceps/suction used?			
7. Did your child experience jaundice?	Y	N	
8. Was there a need for oxygen or respiratory assistance?	Y	N	
9. Were there difficulties with feeding?	Y	N	
10. Did your child bottle feed or breast feed?			
11. Did your child have difficulties sucking?	Y	N	
12. Number of siblings.			
13. Which pregnancy was this child?			
14. Are there any issues with sleep patterns. If so, please explain.			

Medical History

15. Has your child had any of the following illnesses? Please list treatments/medications used.	Yes	No	
a. Meningitis	Y	N	
b. Chicken Pox	Y	N	
c. Seizures	Y	N	
d. Frequent Ear Infections Does your child have P.E. tubes? Please include last hearing test results, where and when completed.	Y Y	N N	
e. Excessive vomiting or reflux. Does/did your child Irritability/fussiness following feedings? Please describe. Are there any current or previous feeding or swallowing difficulties. Please describe.	Y	N	
f. Cleft Palate	Y	N	
g. Does your child have vision problems?	Y	N	
h. Does your child use any adaptive equipment? Describe.	Y	N	
i. Is there a history of respiratory illnesses or asthma?	Y	N	
j. Is there a history of abuse (physical or sexual)?	Y	N	
k. Is your child on any medications? Please list current and past.			

I. Please describe any pertinent medical conditions not mentioned above. (ie, accidents, injuries...)

GROWTH AND DEVELOPMENT

16. What age did your child:	AGE-COMMENTS	NA
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. babble?		
h. speak first word?		
i. speak 2 word sentences?		
j. drink from an open cup? What kind of cup does your child currently use?		
k. use a spoon?		
l. dress independently?		
m. toilet trained?		
n. toilet trained through the night?		

Check the following items that your child is able to do:

Hand preference right left

jump up and down hop on one foot skip catch a ball kick a ball climb/descend stairs alternate foot

17. Describe your child:	YES	NO	COMMENTS
a. is mostly quiet	Y	N	
b. is overly active	Y	N	
c. tires easily	Y	N	
d. talks constantly	Y	N	
e. impulsive	Y	N	
f. restless	Y	N	
g. stubborn	Y	N	
h. resistant to changes	Y	N	
i. over reacts	Y	N	
j. fights frequently	Y	N	
k. is usually happy	Y	N	
l. has frequent temper tantrums	Y	N	
m. is clumsy	Y	N	
n. has difficulty separating from caregiver	Y	N	

o. has nervous habits or tics	Y	N	
p. has poor attention span	Y	N	
q. is frustrated easily	Y	N	
r. has unusual fears, please describe	Y	N	
s. rocks self frequently	Y	N	
t. exhibits difficulty learning new tasks	Y	N	
u. avoids touch	Y	N	
v. craves touch, seeks it out	Y	N	
w. shy, compliant	Y	N	

COMMUNICATION HISTORY

	COMMENTS		
18. How does your child communicate at home, at school...? (ie, sign, PECs, verbal, augmentative/alternative communication device...)			
19. Estimate how many words are in your child's vocabulary?	Expressive (speaking vocabulary) ___ under 25 ___ 25-75 ___ over 75 Receptive (words they understand) ___ under 25 ___ 25-75 ___ over 75		
20. Does your child:			
a. point or gesture to communicate needs?	Y	N	
-gesture instead of using verbal communication?	Y	N	
a. understand and follow simple directions?	Y	N	
b. identify body parts?	Y	N	
c. recognize pictures of common objects?	Y	N	
d. turn his/her head when name is called?	Y	N	
e. communicate with intent?	Y	N	
f. answer "wh" questions?	Y	N	
21. Does your child have a hearing loss?	Y	N	
22. Does your child use a pacifier/nuk/suck thumb?	Y	N	
23. Is a language other than English spoken at home? If so, which one?	Y	N	
24. Please describe any communication difficulties.			
25. When was the problem first noticed			

SOCIAL/EMOTIONAL DEVELOPMENT

26. Is your child easily managed at home?	Y	N	
27. Who manages him/her best?			
28. Does your child empathize with others feelings (happy, sad, angry...)?	Y	N	

29. Does your child understand punishment and does he/she show remorse?	Y	N	
30. Does your child understand praise and reward?	Y	N	
31. Does your child recognize danger (climbing on ladders...)?	Y	N	
32. Does your child show concern when separated from parents?	Y	N	
33. Is your child affectionate toward familiar adults?	Y	N	
34. Does your child have friends?	Y	N	

EDUCATIONAL BACKGROUND

35. Does your child attend school? Where?	Y	N	
36. What grade is he/she in now?	Y	N	
37. Does your child receive special education or therapies in school? (OT, PT, Speech, frequency, length of sessions, individual/group..).	Y	N	
38. What is his/ her current teacher's name?			
39. May we communicate with school staff? Please complete "Consent Form".	Y	N	
40. Does your child receive therapy in school? If so, please describe. Please list School Therapist's names/phone numbers:			If applicable, please provide a copy of your child's current IEP. This will help us provide treatment without duplication of services.

Please list below where your child has received therapy or treatment related to his/her present problems.

Is there anything else you want us to know about your child/family?

What are your goals for your child seeking therapy?

Thank you for completing this form. We understand that this is a lot of information. We require that it is returned to the clinic at least **2 days prior to the assessment**. This information is pertinent to the assessment process. It also allows us to be able to spend as much time with your child during your scheduled time and will help us complete the assessment process more accurately and completely.