

Pediatric Therapy Center Case History Form

Child's Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Address: _____

Primary Care Physician/Pediatrician: _____ Referred by: _____

What concerns you regarding this child: _____

Birth/Medical History

Pregnancy was _____ weeks

Weight: _____ Ounces: _____ Length: _____

Method of delivery: Vaginal C-Section

Reason for C-section _____

Any difficulty at time of birth: Yes No

If yes, please explain:

Any difficulty after birth: Yes No

If yes, please explain:

Is your child receiving medications at this time: Yes No

Please list:

Conditions immediately following birth:

	Yes	No
Difficulty breathing		
Head Injury		
Sucking or swallowing difficulties		
Unusual muscle tone		
Jaundice		
Feeding Tube		
Mother and child discharged separately		

Health and Medical History

1. General Health condition is (circle one) excellent good poor
2. Has your child had any surgeries? _____
3. Does your child have any medical diagnosis (ADHD, Autism etc)? Yes No

If yes, please state the name of the doctor who gave the diagnosis:

4. Has your child experienced:

	Yes	No
High fevers lasting longer than 1 day	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/fainting/staring spells	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems:	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds or sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Removal of tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing/ chewing problems	<input type="checkbox"/>	<input type="checkbox"/>
Pressure Equalization tubes	<input type="checkbox"/>	<input type="checkbox"/>
Drainage from the ear	<input type="checkbox"/>	<input type="checkbox"/>

Developmental History

1. Please indicate the age of your child when he/she accomplished the following:

Followed objects with eyes	_____	Walked	_____
Held objects	_____	Self –Fed	_____
Picked up objects	_____	Dressed Self	_____
Rolled over	_____	Use scissors	_____
Sat Alone	_____	Potty trained	_____
Crawled	_____	Drawing/coloring	_____

Indicate with a check mark any areas of difficulty:

Zippers/ Buttons	Cutting on a line or around a shape	Pulling to sit/stand	
Hopping	Running	Walking	
Jumping	Standing at furniture	Walking up/down steps	
Lift head while on stomach	Standing alone	Building towers	
Roll over	Bearing weight on arms	Putting on socks and shoes	
Sitting alone	Transferring object from one hand to another	Putting on pants and shirt	
Creeping on hands and feet	Throwing ball over head	Drawing and coloring	
Bringing hands at midline	Walking up and down stairs	Crossing midline	

2. Has there been any unusual motor development? _____

Child's physical development has been Fast _____ Normal _____ Slow _____

3. Is your child's balance good? _____ Does your child appear clumsy? _____

4. Does your child use any adaptive equipment (crutches, walker, braces for feet)? _____

If so please describe the equipment: _____

Speech and Language History

1. When were you first concerned about your child's speech?

2. Indicate the ages you noticed the following.

Babbling _____

First word _____

Combined words _____

Simple sentences _____

3. Are there any other languages spoken at home? Yes _____ No _____

If yes, list languages spoken at home

4. Is there family history of speech and/or language difficulties? _____ explain:

5. What is the primary method your child uses for letting you know what he/she wants:

Looking at objects _____

Vocalizing /grunting _____

Crying _____

Pointing/gestures _____

Single words _____

2-3 words _____

combinations _____

sentences _____

6. Which of the following best describes your child's speech?

Easy to understand _____

Almost never understood by others _____

Difficult for parents to understand _____

Difficult for others to understand _____

Different from other children the same _____

age

Feeding History:

At what age did your child start drinking from a cup? _____

At what age did your baby eat baby food? _____

At what age did your child eat junior foods? _____

Did your child have difficulty transitioning between foods? _____

Family status

1. Who resides in the child's home? ___Mother ___Father ___siblings ___
Other

2. Father's Occupation: _____ Age: _____

3. Mother's Occupation: _____ Age: _____

4. Who cares for your child during the day? _____

5. What language do they speak? _____

Please list siblings and information below:

Name	Age	Sex	School	Grade reached
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Educational Status

1. Name of school your child attends: _____

2. Grade: _____ Teacher: _____

3. Has your child been kept back at any grade level? _____

4. Does your child have an Individualized Education Plan (IEP) Yes / No

Behavioral Status

Which of the following describe your child's behavior?

- | | |
|---|---|
| <input type="checkbox"/> Easily manage | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Overly talkative | <input type="checkbox"/> Slow Learner |
| <input type="checkbox"/> Jealous | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Plays well with others | <input type="checkbox"/> Does not play well with others |
| <input type="checkbox"/> Thumb sucker | <input type="checkbox"/> Likes School |
| <input type="checkbox"/> Good eye contact | <input type="checkbox"/> No eye contact |
| <input type="checkbox"/> Very active | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bad-tempered |
| <input type="checkbox"/> Still uses pacifier | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Hyper-active | <input type="checkbox"/> Quiet |

Additional Comments:

If there is any information that you would like for us to know about your child that is not already listed on this form, please feel free to describe below.
