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	❑	❑
Seizures/fainting/staring spells	❑	❑
Vision Problems:	❑	❑
Allergies	❑	❑
Ear Infections	❑	❑
Frequent colds or sore throats	❑	❑
Mouth Breathing	❑	❑
Removal of tonsils	❑	❑
Asthma	❑	❑
Head Injury	❑	❑
Swallowing/ chewing problems	❑	❑
Pressure Equalization tubes	❑	❑
Drainage from the ear	❑	❑

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?

- ❑ Easily manage
- ❑ Shy
- ❑ Overly talkative
- ❑ Jealous
- ❑ Plays well with others
- ❑ Thumb sucker
- ❑ Good eye contact
- ❑ Very active
- ❑ Cries easily
- ❑ Still uses pacifier
- ❑ Poor memory
- ❑ Hyper-active
- ❑ Nightmares
- ❑ Temper Tantrums
- ❑ Slow Learner
- ❑ Destructive
- ❑ Does not play well with others
- ❑ Likes School
- ❑ No eye contact
- ❑ Nervous
- ❑ Bad-tempered
- ❑ Short attention span
- ❑ Friendly
- ❑ 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.

_____

_____

_____

_____