Pediatric Case History Form

General Information

Child's name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Parent(s)/Guardian(s):_____

Referred By: _____

Physician: _____ Phone:_____

Siblings and other individuals that live in the child's home? (include names and ages)

_____

_____

What goals would you like to see achieved through speech therapy, occupational therapy or physical therapy services? _____

_____

What are your child's hobbies and favorite interests? _____

Please provide any additional information that you believe would help the therapist get to know your child.

Prenatal and Birth History

Adopted: Yes No

Mother's general health during pregnancy ? (illnesses, accidents, medications, etc.)

_____

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? _____

_____

Was the delivery premature? _____ If so, how many weeks? _____

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma_____ High Fever_____
Head Trauma _____ Seizures_____
Ear Infections_____ Other_____

Has the child had any surgeries? If yes, what type and when (e.g., Tonsillectomy, Adenoidectomy, etc.)?

_____

Describe any major accidents or hospitalizations. _____

Has your child had a vision exam? If yes, what were the results? _____

Has your child had a hearing exam? If yes, what were the results? _____

Is your child currently taking any medications? _____

Does your child have any allergies? _____

Developmental History

At what age did your child achieve the following milestones? Some of the milestones may not be applicable to your child at this time.

Hold head up _____ Roll over _____
Sit independently_____ _____ Crawl on hands and knees _____
Cruise around furniture _____ Walk independently _____
Drink from an open cup_____ Eat solid food_____
Spoon feed independently _____ Tying shoes _____
Toilet trained _____
Use single words (e.g., no, mom, doggie, etc.)_____
Combine words (e.g., me go, daddy shoe, etc.)_____
Name simple objects (e.g., dog, car, tree, etc.)_____
Use simple questions (e.g., Where's doggie? etc.)_____
Engage in a conversation: _____

Educational History

School: _____Grade:_____

Teacher(s):_____

Does the child receive special services (IEP)? _____If yes, please provide a copy of the IEP.

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)? _____

_____

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Activities of Daily Living (Write N/A if no concerns in this area) _____

Is your child able to perform the following self-help skills?

Dresses self _____
Toileting _____
Washes hands _____
Drinks from an open cup _____
Buttons _____
Puts on shoes _____
Ties shoes _____
Undresses self _____
Brushes teeth _____
Feeds self _____
Zippers _____
Snaps _____
Puts on socks _____

Sensory History (Write N/A if no concerns in this area) _____

Please feel free to expand upon and describe any concerns within this subject area.

Does your child become upset when getting messy or dirty (e.g., dirt, glue, finger painting, etc.)? _____

_____

Does your child seem to crave jumping or falling into objects or people? _____

_____

Does your child become upset when hearing an unexpected or loud sound? _____

Does your child have difficulty discriminating between the size and shape of an object?

_____

Does your child seem overly cautious on playground equipment? _____

Gross Motor Skills/Motor Planning (Write N/A if no concerns in this area) _____

Is your child able to……..

Hop/balance on one foot? YES NO
Skip? YES NO
Climb on or over objects? YES NO
Jump with both feet together? YES NO
Ride a tricycle? YES NO
Ride a bicycle without training wheels? YES NO
Jump rope? YES NO
Kick a ball? YES NO
Throw/catch a ball? YES NO
Dribble a ball? YES NO
Pump self on a swing? YES NO
Ascend and descend stairs? YES NO

Does your child…

Have slow and deliberate movements with motor activities? YES NO
Move quickly and loose control? YES NO
Seem uncoordinated or awkward? YES NO
Have difficulty running? YES NO
Have difficulty learning new skills? YES NO

Fine Motor Skills (Write N/A if no concerns in this area) _____

Is your child able to……..

Cut with scissors? YES NO
Color inside the lines? YES NO
Play with manipulative toys? YES NO

Does your child…

Have difficulty holding a pencil correctly? YES NO
Reverse letters when writing? YES NO
Have difficulty with spacing and sizing of letters? YES NO
Express fatigue when writing? YES NO
Become easily frustrated when writing? YES NO
Have difficulty copying shapes? YES NO
Have difficulty remaining on a line when writing? YES NO

Feeding/Oral Motor (Write N/A if no concerns in this area) _____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, choking, drooling, chewing, etc.)? If yes, please describe. _____

_____

Have there ever been any concerns with the intake of liquids (e.g., choking, aspiration)? _____

Are your child's food preferences a concern? YES NO

Does your child prefer certain textures (e.g., crunchy, soft, chewy, etc.) or flavors (e.g., sweet, salty, sour, etc.) of food? _____

What are some of the typical foods in your child's diet? _____

Does your child gag when eating certain foods or textures? _____

Does your child use a pacifier or suck their thumb? _____

Does your child become upset with their teeth being brushed? _____

Does your child require a special diet? _____

Does your child have a history of reflux? _____

Speech/Language (Write N/A if no concerns in this area) _____

Describe your child's speech-language problem: _____

_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions? _____

_____

Are there any other speech, language, or hearing problems in your family? If yes, please describe in the space below.

Person completing form: _____

Relationship to child: _____

Signed: _____Date:_____