# CHILDREN'S CASE HISTORY FORM

*Form Completed By:* ________________ *Date:* ____________
*Relationship to Child:* ________________

*Who referred you to our clinic?* __________________________

**CHILD AND FAMILY INFORMATION:**

**Child's Name:** ___________________________________________________
First Middle Last

Name your child likes to be called: __________________

**Date of Birth**: ____________

**Mother's Name:** __________________________________

**Father's Name:** ___________________________________

**Address:** ______________________________________

______________________________________

**Phone Numbers**: Home: __________________________

Mother Cell: ______________________

Father Cell: _______________________

**Email Addresses** (for therapist's use only):

Mother: _______________________________________

Father: _______________________________________

**Does your child live with both parents?** _______________

If not, please describe living arrangements: _________________________

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**Please list siblings living in the child's home:**

| Name | Age | Gender | Special Needs |
|---|---|---|---|
| _______________________ | _____ | _____ | _______________ |
| _______________________ | _____ | _____ | _______________ |
| _______________________ | _____ | _____ | _______________ |

**Is English the only language spoken in the home?** ________

If not, what other language is spoken? _____________________

If not, what percentage of the time is English spoken?___________

**Does your child attend school**? ____________
If so, what is the name of the school? ______________________
What days/hours does your child attend? ___________________________
______________________________________________________________

**What extra-curricular activities does your child have**? ___________________

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**What toys and activities does your child particularly enjoy:** ______________

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**Please tell us why you are seeking an evaluation for your child**: _________

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**What have you tried previously to help your child with this concern?**
(Please include places, dates and outcomes of any previous or current therapies)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Is there a family history of anything pertinent to this evaluation (stuttering, voice disorder, autism, cognitive deficits, etc.)?** ___________

If yes, please explain: ____________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Check any of the following factors which you feel may have contributed, or are contributing to your child's present difficulties. Check as many items as you think are present.**

______Autism/Asperger/PDD
______Hearing Problems
______Learning Disability
______Cognitive Deficit
______Feeding/Eating Problems
______Concussion/Head Injury
______Behavioral Problems
______Emotional Problems of Child
______Environmental Factors
______Sleeplessness
______Thumb Sucking/Pacifier
______Other: ____________________

**When is your child available for therapy?** ______________________________
______________________________________________________________________
______________________________________________________________________

## DEVELOPMENTAL HISTORY:

### *Birth History*

Length of pregnancy: _______ weeks

Birth Weight: _____ pounds, _______ ounces

Describe mother's health during pregnancy: ____________________________

Describe any unusual conditions which existed during this pregnancy (Rh incompatibility, hemorrhage, physical illness, accident, emotional upset, etc.):

Describe any complications during or after the birth of your child (type of birth, special medical procedures): ________________________________________

Describe the health of your child during the first days of life (Apgar scores, abnormalities, breathing problems, jaundice, etc.): _______________________

Describe anything else you feel is important about your child's birth and hospital stay: ____________________________________________________________

***Injuries and Illnesses:***

**Has your child's vision been tested?** ________ When?_________
By Whom? ____________________Results_______________

**Has your child's hearing been tested?** ________ When?_________
By Whom? ____________________Results_______________

**Check any of the following health issues your child has had:**

| | | Age of Onset/Duration |
|---|---|---|
| ___ | Seizures | _____________ |
| ___ | High Fevers | _____________ |
| ___ | Allergies | _____________ |
| ___ | Frequent Colds | _____________ |
| ___ | Asthma/RSV | _____________ |
| ___ | Pneumonia | _____________ |
| ___ | Ear Infections | _____________ |
| ___ | Tubes | _____________ |

**Please explain in detail any items checked above** (please use the back if necessary):

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Does your child take any medications?** ________ **Please list:**

______________________________________________________________

**Any other health issues**? If so, please explain: __________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

***Gross and Fine Motor Milestones:***

**When did your child first do the following?**

| Skill: | Age: |
| --- | --- |
| Hold head without support | ______ |
| Sit without support | ______ |
| Crawl | ______ |
| Stand alone | ______ |
| Walk alone | ______ |
| Gain bladder control | ______ |
| Gain bowel control | ______ |
| Scribble | ______ |
| Color within outline | ______ |
| Use scissors | ______ |
| Dress without help | ______ |
| Undress without help | |

***Language and Feeding Milestones*:**

**When did your child first do the following?**

| Skill: | Age: |
| --- | --- |
| Coo and gurgle | ______ |
| Babble | ______ |
| Use first words meaningfully | ______ |
| Combine words to make short sentences | ______ |
| Use complete sentences | ______ |
| Use a spoon to eat | ______ |
| Finger feed | ______ |
| Drink from a straw | ______ |
| Drink from a cup without a lid | ______ |

**Does your child have any eating and/or feeding issues?** _________

If yes, please explain: ____________________________________________

______________________________________________________________

______________________________________________________________

**How does your child get liquids (please circle)?**

Breast    bottle    sippy cup    straw    open cup

**Does your child suck his/her thumb?** __________

**Does your child use a pacifier?** __________

***Please fill out the following ONLY if your child is being assessed by an occupational therapist:***

**Please check everything your child can do and indicate age they started, if known:**

*Gross Motor Skills:*

| | Age Started: |
|---|---|
| _____ Pulling to Stand | __________ |
| _____ Jumping with both feet | __________ |
| _____ Standing on 1 foot | __________ |
| _____ Hopping on 1 foot | __________ |
| _____ Hopping Forward on Both Feet | __________ |
| _____ Skipping | __________ |
| _____ Riding big wheel/ tricycle | __________ |
| _____ Riding a bicycle | __________ |

*Fine Motor Skills:*

| | |
|---|---|
| _____ Tracing | __________ |
| _____ Draw a Circle | __________ |
| _____ Draw a Square | __________ |

*Dressing Skills:*

Pulls Off: socks____, shoes____, shirt____, pants____
Puts On: socks____, shoes____, shirt____, pants____
Zips____ Unzips____ Snaps____ Unsnaps____
Buttons____ Unbuttons____ Ties____

*Grooming:*

_____ Washing Hands
_____ Drying Hands
_____ Brushing Teeth
_____ Toileting Independently

**Please check the following if the statement is true:**

_____ Child falls down or is clumsy
_____ Child has difficulty working puzzles
_____ Child has difficulty drawing, or writing
_____ Child has difficulty with running, jumping, or riding a bike (circle which one)
_____ Child has difficulty focusing, sitting still in circle time/ school/ home
_____ Child has difficulty calming down when upset
_____ Child does not enjoy swings, slides and/or roller coasters
_____ Child has aversions to textures such as shaving cream, sand
_____ Child can be overly active

***Please fill out the following ONLY if your child is being assessed by a speech language pathologist:***

***If your child speaks in complete sentences,*** what percent of the time do the following people understand what your child says?

Mother _____ Father _____ Siblings _____ Strangers _____

***If your child does not speak in complete sentences,*** please answer the following questions:

How does your child ask for desired objects? ____________________________

____________________________________________________________

How does your child ask for help when needed? __________________________

____________________________________________________________

How does your child communicate when s/he doesn't want an object or doesn't want to do something? _____________________________________________

____________________________________________________________

____________________________________________________________

How does your child tell you how s/he feels, either physically or emotionally?___

____________________________________________________________

____________________________________________________________

How does your child greet people and/or tell them good-bye? _______________

____________________________________________________________

____________________________________________________________

Does your child enjoy and/or attempt to communicate with similarly-aged peers and siblings? ____________________________________________________

____________________________________________________________

Does your child interact effectively with similarly-aged peers and siblings? _____

____________________________________________________________

____________________________________________________________

List words and phrases your child currently says spontaneously: _____________

____________________________________________________________

____________________________________________________________

***Please fill out the following ONLY if your child is being assessed for an oral-myofunctional (tongue thrust) evaluation:***

**When was the possible oral myofunctional disorder first noticed?**

______________________________________________________________

**Who diagnosed the possible oral myofunctional disorder?**

______________________________________________________________

**Do you have any feelings about possible causes of any oral myofunctional disorder?**

______________________________________________________________

______________________________________________________________

**Does your child suffer from seasonal allergies?** _______

If so, how has the problem been treated? (Example: allergy injections. over-the-counter medications, prescriptions, etc)

_________________________________________________________

_________________________________________________________

***Dental History:***

Who is your child's general dental care provider? ____________________

Approximately when was the child last seen by the dental care provider?

_______________________

Who is your child's orthodontist? __________________________________

Approximately when was the child last seen by the orthodontist?

_______________________

Did your child's primary teeth erupt at the expected time? ________

Approximately, when did the permanent teeth first appear? ________

Does your child have a history of sucking finger/thumb or fabric? ________

Does your child have a known sensitivity to hot/cold? ________

Do you consider your child to be a "mouth breather"? ________

Has your child ever worn an orthodontic appliance? ________