Children's Therapy Center, Inc.

Child Case History Email Form

Children's Therapy Center, Inc. requests this information for the sole purpose of completing the Evaluation. Completion of this form is required prior to your child's scheduled Evaluation.

Child's Name: ______________________________ **DOB:** ____________

Parent/Guardian: ______________________________ **Date:** ____________

Please check (X) the reason(s) for the Evaluation: Explain your concerns about your child

Fine Motor __ ______________________________
Gross Motor __ ______________________________
Speech __ ______________________________
Language __ ______________________________
Sensory __ ______________________________
Mobility __ ______________________________
Feeding __ ______________________________
Behavior __ ______________________________

Requesting which Therapy?: check (X) Occupational Therapy ___ Speech Therapy ___ Physical Therapy ___

Please list previous diagnosis, if any / who diagnosed / and when:

Where: ____________ By ____________________ When ________
Where: ____________ By ____________________ When ________

THERAPY PRECAUTIONS Please be specific YES (**Y**) or NO (**N**) **Details** (Not Applicable enter "NA")

- Does your child have any known allergies (i.e. food, latex)? ____ ____ ______________________
- Has your child been diagnosed with Down Syndrome, ____ ____
  …has he/she been diagnosed with Atlantoaxial Instability? ____ ____
  …Are there any movement restrictions? ____ ____ ______________________
- Are there any precautions not listed above that we should know about? Please describe. (i.e. dietary restrictions) ____ ____ ______________________

FAMILY HISTORY

(Use the numbers below to identify family member that applies to the following questions)

1. **Father's Name:** ______________________ Occupation ______________________
2. **Mother's Name:** ______________________ Occupation ______________________

Who lives in the house with the child? (If children are listed give names and ages) **Father?** (Y or N): __ **Mother?** (Y or N): __

3. __________ 4. __________ 5. __________ 6. __________ 7. __________

Parents Marital Status: (Enter "X" or number from above [1 or 2] to which apply to status)
___ Married ___ Single ___ Living together ___ Separated ___ Divorced ___ Remarried

Have there been instances of the following in your immediate or extended family members: (Enter family member number from above)
____ ADHD ____ Learning Disabilities ____ Dyslexia ____ Communication Disorders ____ Autism/PDD ____ Hearing Loss ____ Stuttering

Is your child adopted? ___ If so, at what age: ___ from where/what country: ______________________

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PREGNANCY AND BIRTH HISTORY

	YES (Y) or NO (N)	Details Please be specific (Not Applicable enter "NA")
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy?		
2. Was this pregnancy full-term? If not, give gestational age and weight at time of delivery.		
3. Were any drugs or medications taken during this pregnancy? If so, please specify.		
4. Was labor/delivery normal (vaginal, breech, caesarian)?		
Labor medications administered (and how many times)?		
5. Please list birth weight and length.		
6. Did your child experience jaundice?		
7. Was there a need for oxygen or respiratory assistance?		
8. Were there difficulties with feeding/sucking?		
9. Did your child bottle feed or breast feed?		
10. Were there any issues with sleep patterns?		

MEDICAL HISTORY

Has your child had any of the following illnesses?	YES (Y) or NO (N)	Details Please be specific. Please list treatments/medications used.
- Meningitis		
- Chicken Pox		
- Seizures		
- Hearing a. Frequent Ear Infections		
b. Does your child have P.E. tubes?		
c. Last hearing test (when & where) & results		
- Vomiting, reflux, fussiness following feedings, feeding or swallowing difficulties		
- Cleft Palate		
- Vision problems - Last test (when & where) & results		
- Does your child use any adaptive equipment? (describe)		
- History of respiratory illnesses or asthma		
- History of abuse (physical or sexual)		
- Child's medications - Current		
- Past		
- Please describe any pertinent medical conditions not mentioned above. (ie, accidents, injuries…)		

GROWTH AND DEVELOPMENT

1. What age did your child:

	Age	Details/Comments
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		

2. Your child's hand use preference: check one (X) Right __ Left __

3. Your child is now able to do: check (X)

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

4. Describe your child: Accurate statement? YES (**Y**) or NO (**N**) **Comments**

	Y	N	Comments
a. Mostly quiet	____	____	____
b. Overly active	____	____	____
c. Tires easily	____	____	____
d. Talks constantly	____	____	____
e. Impulsive	____	____	____
f. Restless	____	____	____
g. Stubborn	____	____	____
h. Resistant to changes	____	____	____
i. Over reacts	____	____	____
j. Fights frequently	____	____	____
k. Is usually happy	____	____	____
l. Has frequent temper tantrums	____	____	____
m. Is clumsy	____	____	____
n. Has difficulty separating from caregiver	____	____	____
o. Has nervous habits or tics	____	____	____
p. Has poor attention span	____	____	____
q. Is frustrated easily	____	____	____
r. Has unusual fears, please describe	____	____	____
s. Rocks self frequently	____	____	____
t. Exhibits difficulty learning new tasks	____	____	____
u. Shy, compliant	____	____	____

COMMUNICATION HISTORY

1. How does your child communicate at home and at school? (i.e., sign, PECs, verbal, augmentative/alternative communication device…)

Describe: ____________________

2. Estimate how many words are in your child's vocabulary:

Expressive (speaking vocabulary): Check (X) under 25 __ 25-75 __ over 75 __

Receptive (words they understand) Check (X) under 25 __ 25-75 __ over 75 __

3. Does your child: YES (**Y**) or NO (**N**) **Comments**

	Y	N	Comments
a. Point or gester to communicate needs?	____	____	____
Gesture instead of using verbal communication?	____	____	____
b. Understand and follow simple directions?	____	____	____
c. Identify body parts?	____	____	____
d. Recognize pictures of common objects?	____	____	____
e. Turn his/her head when name is called?	____	____	____
f. Communicate with intent?	____	____	____
g. Answer "wh" questions? (who, what, where, when)	____	____	____

	Y	N	Comments
4. Does your child use a pacifier/nuk/suck thumb?	____	____	____
5. Is a language other than English spoken at home? If so, which language?	____	____	____
6. Communication difficulties (please describe & age noticed)	____	____	____

SOCIAL/EMOTIONAL DEVELOPMENT

YES (Y) or NO (N) — **Details** Please be specific

1. Is your child easily managed at home? Who manages him/her best? ____ ____ ______________________
2. Does your child empathize with others feelings? (happy, sad, angry…) ____ ____ ______________________
3. Does your child understand punishment and does he/she show remorse? ____ ____ ______________________
4. Does your child understand praise and reward? ____ ____ ______________________
5. Does your child recognize danger? (like climbing on ladders…etc) ____ ____ ______________________
6. Does your child show concern when separated from parents? ____ ____ ______________________
7. Is your child affectionate toward familiar adults? ____ ____ ______________________
8. Does your child have friends? ____ ____ ______________________

EDUCATIONAL BACKGROUND

YES (Y) or NO (N) — **Details** Please be specific

1. Does your child attend school? Where? ____ ____ ______________________
2. What grade is he/she in now? ______________________
3. Does your child receive special education or therapies in school? (OT, PT, Speech, frequency, length of sessions, individual/group...) ____ ____ ______________________
4. May we communicate with school staff? If so, please indicate teacher's name and phone number. ____ ____ ______________________

MISCELLANEOUS INFORMATION

Details Please be specific

1. Does/has your child received therapy services outside of school currently/past? If so, please describe. ______________________
2. Briefly describe a typical day with your child ______________________
3. Describe your child's strengths ______________________
4. What are your treatment priorities for your child? ______________________

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. ***You may email the completed forms to: info@childrenstherapyctr.com***