Children's Therapy Center, Inc.

Child Case History Form

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

Child's Name:____**DOB:**____________________

Parent/Guardian:____________________________________**Date:**____________________

Please check the reason for the Evaluation:

- Fine Motor
- Gross Motor
- Speech
- Language
- Sensory
- Mobility
- Feeding
- Behavior

Explain your concerns about your child:

____

Requesting which Therapy?

☐ Occupational Therapy
☐ Speech Therapy
☐ Physical Therapy

Please list diagnosis, if any, who diagnosed, and when your child was diagnosed: ________________________

____

*** THERAPY PRECAUTIONS -** Please be specific

Does your child have any known allergies you are aware of (i.e. food, latex, medications)? Please list.	**YES**	**NO**	
If your child has Down syndrome, has he/she been diagnosed with Atlantoaxial Instability? Are there any movement restrictions?	**Y**	**N**	
Are there any precautions not listed above that we should know about. Please describe. (i.e. dietary restrictions)	**Y**	**N**	

*** FAMILY HISTORY**

Parent 1:	Age:	Occupation:
Parent 2:	Age:	Occupation:
Is child adopted? ____________________	If so, at what age, and from where/what country:	
Are parents (circle one): Married Single Living together Separated Divorced Remarried		
Who lives in the house with this child, other than the parents? (If children are listed, please give names and ages)		
Have there been any instances of the following in your immediate or extended family members: O ADHD O Learning Disabilities O Dyslexia O Communication Disorders O Autism/PDD O Hearing Loss O Stuttering		

* PREGNANCY AND BIRTH HISTORY

	YES	NO	COMMENTS
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe.	**Y**	**N**	
2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery.	**Y**	**N**	
3. Were any drugs or medications taken during this pregnancy? If so, please specify.	**Y**	**N**	
4. Was labor/delivery normal?	**Y**	**N**	Type of delivery (circle one): **Vaginal, Breech or Caesarian?**
5. Please list birth weight and length.			
6. Did your child experience jaundice?	**Y**	**N**	
7. Was there a need for oxygen or respiratory assistance?	**Y**	**N**	
8. Were there difficulties with feeding/sucking?	**Y**	**N**	
9. Did your child bottle feed or breast feed?			
10. Are there any issues with sleep patterns? If so, please explain.	**Y**	**N**	

* MEDICAL HISTORY

1. Has your child had any of the following illnesses? Please list treatments/medications used.	**Yes**	**No**	
a. Meningitis	**Y**	**N**	
b. Chicken Pox	**Y**	**N**	
c. Seizures	**Y**	**N**	
d. Frequent Ear Infections Does your child have P.E. tubes? Please include last hearing test results Where and when completed	**Y** **Y**	**N** **N**	
e. Does/did your child have any of the following: vomiting, reflux, fussiness following feedings, feeding or swallowing difficulties? If so, please describe:	**Y**	**N**	
f. Cleft Palate	**Y**	**N**	
g. Does your child have vision problems?	**Y**	**N**	
h. Does your child use any adaptive equipment? If so, please describe.	**Y**	**N**	
i. Is there a history of respiratory illnesses or asthma?	**Y**	**N**	
j. Is there a history of abuse (physical or sexual)?	**Y**	**N**	
k. Is your child up to date with vaccinations?	**Y**	**N**	**I choose not to vaccinate my child. Y N**
l. Has your child had or knowingly been exposed to the CMV Virus?	**Y**	**N**	
m. Is your child on any medications? Please list current and past.			

n. Please describe any pertinent medical conditions not mentioned above. (ie, accidents, injuries…)

* GROWTH AND DEVELOPMENT

1. What age did your child:	**AGE / COMMENTS**
a. Roll over from stomach to back?	
b. Roll from back to stomach?	
c. Sit independently?	
d. Belly crawl?	
e. Hands and knees crawl?	
f. Cruise around furniture?	
g. Walk independently?	
h. Babble?	
i. Speak first word?	
j. Speak 2 word sentences?	
k. Drink from an open cup? What kind of cup does your child currently use?	
l. Use a spoon?	
m. Dress independently?	
n. Toilet trained?	
o. Toilet trained through the night?	

Check the following items that your child is able to do: Hand preference: Right Left

O jump up and down **O** hop on one foot **O** skip **O** catch a ball **O** kick a ball **O** climb/descend stairs alternate foot

2. Describe your child:	**YES**	**NO**	**COMMENTS**
a. Is mostly quiet	**Y**	**N**	
b. Is overly active	**Y**	**N**	
c. Tires easily	**Y**	**N**	
d. Talks constantly	**Y**	**N**	
e. Impulsive	**Y**	**N**	
f. Restless	**Y**	**N**	
g. Stubborn	**Y**	**N**	
h. Resistant to changes	**Y**	**N**	
i. Over reacts	**Y**	**N**	
j. Fights frequently	**Y**	**N**	
k. Is usually happy	**Y**	**N**	
l. Has frequent temper tantrums	**Y**	**N**	

m. Is clumsy	**Y**	**N**	
n. Has difficulty separating from caregiver	**Y**	**N**	
o. Has nervous habits or tics	**Y**	**N**	
p. Has poor attention span	**Y**	**N**	
q. Is frustrated easily	**Y**	**N**	
r. Has unusual fears, please describe	**Y**	**N**	
s. Rocks self frequently	**Y**	**N**	
t. Exhibits difficulty learning new tasks	**Y**	**N**	
u. Shy, compliant	**Y**	**N**	

*** COMMUNICATION HISTORY**

1. How does your child communicate at home, at school…? (ie, sign, PECs, verbal, augmentative/alternative communication device…)	Comments:
2. Estimate how many words are in your child's vocabulary?	Expressive (speaking vocabulary) ____ under 25 _____ 25-75 _____ over 75 Receptive (words they understand) ____ under 25 _____ 25-75 _____ over 75

3. Does your child:	**Yes**	**No**	
a. Point or gesture to communicate needs? Gesture instead of using verbal communication?	**Y** **Y**	**N** **N**	
b. Understand and follow simple directions?	**Y**	**N**	
c. Identify body parts?	**Y**	**N**	
d. Recognize pictures of common objects?	**Y**	**N**	
e. Turn his/her head when name is called?	**Y**	**N**	
f. Communicate with intent?	**Y**	**N**	
g. Answer "wh" questions?	**Y**	**N**	
4. Does your child use a pacifier/nuk/suck thumb?	**Y**	**N**	
5. Is a language other than English spoken at home? If so, which language?	**Y**	**N**	
6. Please describe any communication difficulties:			
7. At what age were the difficulties first noticed?			

*** SOCIAL/EMOTIONAL DEVELOPMENT**

1. Is your child easily managed at home? If so, who manages him best?	**Y**	**N**	
2. Does your child empathize with others feelings (happy, sad, angry…)?	**Y**	**N**	
3. Does your child understand punishment and does he/she show remorse?	**Y**	**N**	
4. Does your child understand praise and reward?	**Y**	**N**	
5. Does your child recognize danger (like climbing on ladders…etc)?	**Y**	**N**	

6. Does your child show concern when separated from parents?	**Y**	**N**	
7. Is your child affectionate toward familiar adults?	**Y**	**N**	
8. Does your child have friends?	**Y**	**N**	

*** EDUCATIONAL BACKGROUND**

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

*** MISCELLANEOUS INFORMATION**

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.