Children's Therapy Center, Inc.
childrenstherapyctr.com

Eagan, MN
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Apple Valley, MN
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Patient Case History Questionnaire

Patient's Name:____ Birthdate:________________________

Gender: ☐ Male ☐ Female ☐ Prefer not to specify

Person Completing Form: ________________________ Today's Date: _________________________________

Intake Information	
Why were you referred for an evaluation? Check all that apply.	☐ Fine motor ☐ Gross motor ☐ Sensory ☐ Mobility ☐ Speech clarity ☐ Language ☐ Social skills ☐ Swallowing ☐ Feeding ☐ Stuttering ☐Behavior
Which therapies are you requesting? Check all that apply.	☐ Occupational Therapy ☐ Physical Therapy ☐ Speech and Language Therapy ☐ Feeding Therapy
Explain your reasons for pursuing this evaluation and treatment priorities:	
Does your child have any medical diagnoses? If yes, please indicate the date of diagnosis and the name of the provider who made the diagnosis. *provide additional information in the space above.	☐ No ☐ Yes Diagnosis:________________________ Date:________________________ Provider: ________________________ Diagnosis:________________________ Date:________________________ Provider: ________________________ Diagnosis:________________________ Date:________________________ Provider: ________________________
Will interpreter services be required for the evaluation?	☐ No ☐ Yes
What is the child's primary language(s)? Are other languages spoken in the home? If yes, please list.	Primary Language:________________________ ☐ No ☐ Yes: ________________________ ________________________

Birth History	
Were there any complications during pregnancy?	☐ No ☐Yes ________________________ ________________________ ________________________
Were drugs or medications taken during pregnancy?	☐ No ☐ Yes,________________________ ________________________ ________________________

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Was this pregnancy full term?	☐ No ☐ Yes Gestational age:
Delivery	☐ vaginal ☐ caesarian Hospital: ____ Birthing Center: __________________________________ Home Birth:_______________________________________
Complications during delivery?	☐ No ☐ Yes ________________________________ ____ ____
Weight at time of delivery:	________ pounds ________ ounces
Apgar scores (if known):	
Did your child require a stay in the NICU? If yes, how long?	☐ No ☐ Yes________________________________ ____
Did your child experience respiratory difficulties?	☐ No ☐ Yes
Was there a need for oxygen or respiratory assistance?	☐ No ☐ Yes, please describe _________________ ____ ____
Did your child experience jaundice?	☐ No ☐ Yes
Did your child experience initial feeding difficulties?	☐ No ☐ Yes, please describe _________________ ____ ____ ____

Medical History	
Has your child had any of the following? Please check those that apply.	☐ Seizures ☐ Head injury ☐ High fevers ☐ Respiratory illness ☐ Asthma ☐ Sinusitis ☐ Sleeping difficulties ☐ Cleft palate ☐ immunodeficiency ☐ Tonsillitis ☐Tonsillectomy ☐ Adenoidectomy ☐ Sucking thumb/fingers/pacifier ☐ Constipation issues ☐ Meningitis ☐ Measles ☐ Chickenpox ☐ Other:_________________________
Has your child had or knowingly been exposed to the CMV virus?	☐ No ☐ Yes
Has your child had any of the following? Please check all that apply.	☐ G-tube ☐ Swallowing difficulties ☐ Reflux ☐ Feeding difficulties ☐ Food avoidances ☐ Video swallow study
Does your child wear glasses? Does your child have a history of vision problems?	☐ No ☐ Yes ☐ No ☐ Yes, please describe: __________________ ____ ____

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Has your child had a vision assessment? If yes, when and where was the most recent vision assessment?	☐ No ☐ Yes Date: ____________ Location: ________________ Results:______________________________________
Has your child had a hearing evaluation? If yes, when and where was your child's most recent hearing evaluation?	☐ No ☐ Yes Date: ____________ Results:___________________ Audiologist:__________________________________ Clinic:_______________________________________
Does your child have a history of ear infections or middle ear fluid?	☐ No ☐ Yes, age of first infection:____________ How many have they had? ____________________
Has your child had ear tubes?	☐ No ☐ Yes How many sets? ___________
Please describe any pertinent medical conditions not mentioned above.	
Is your child regularly followed by other specialties? If yes, please list. *provide additional information in the space above.	☐ No ☐ Yes Provider & Specialty:___________________________ Clinic:_______________________________________ How often are they seen? _____________________ Provider & Specialty:___________________________ Clinic:_______________________________________ How often are they seen? _____________________

Growth and Development

What age did your child…	
Roll from stomach to back:	Use feeding utensils:
Roll from back to stomach:	Drink from open cup:
Sit independently:	Dress independently:
Belly crawl:	Toilet trained:
Crawl on hands/knees:	Toilet trained through the night:
Stand independently:	Babble:
Cruise furniture:	Speak first word:
Walk independently:	Speak 2 word sentences:
Check all of your child's current motor skills	☐ Jump up and down ☐ Hop on one foot ☐ Skip ☐ Catch a ball ☐ Kick a ball ☐ Climb/descend stairs alternating feet
Hand preference	☐ Right ☐ Left ☐ Uses both hands equally
Check all that describe your child	☐ Overly active ☐ Tires easily ☐ Clumsy ☐ Impulsive ☐Resistant to change ☐ Unusual fears ☐ Frequent tantrums ☐ Nervous habits/tics ☐ Usually happy ☐ Sensory seeking behaviors ☐ Poor attention span

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Are your child's behaviors easily managed by caregivers?	☐ Yes ☐ No, please describe:__________________ ____ ____
Does your child…? (check all that apply)	☐ Empathize with others' feelings ☐ Understand consequences ☐ Understand praise/reward ☐ Recognize danger ☐ Draw attention by pointing ☐ Follow directions ☐ Participate in imaginative play ☐ Make eye contact ☐ Show affection to familiar caregivers ☐ Have difficulty separating from caregivers
Describe your family's daily routine. What part(s) does your child struggle with? ____ ____ ____ ____	
Describe your child's strengths and challenges: ____ ____ ____ ____	

Therapy Precautions

Does your child have any known allergies (i.e. food, latex, environmental)? If yes, please list the allergy type, when and where diagnosed, and response to exposure.	☐ No ☐ Yes: ________________________________ ____ ____ ____ ____ ____ ____
Does your child have any dietary requirements or other therapy precautions you would like us to be aware of? (e.g. vegetarian, halal diet, etc.)	☐ No ☐ Yes: ________________________________ ____ ____
Is your child on any medications? If yes, please list below.	☐ No ☐ Yes
Medication: ________________________________ Dosage:___________________________________ Date initially prescribed:____________________	Medication: ________________________________ Dosage:___________________________________ Date initially prescribed:____________________
Medication: ________________________________ Dosage:___________________________________ Date initially prescribed:____________________	Medication: ________________________________ Dosage:___________________________________ Date initially prescribed:____________________

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Is your child up to date on vaccinations?	☐ No ☐ Yes
Have you chosen to opt-out of vaccinating your child?	☐ No ☐ Yes
Does your child have Atlantoaxial Instability or restrictions for weight bearing?	☐ No ☐ Yes: ________________________________ ____
Does your child use adaptive equipment? (e.g. hearing aids, gait trainer, AFOs, forearm crutches, cochlear implants)	☐ No ☐ Yes, please describe __________________ ____ ____
What is your child's primary mode of communication? Check all that apply.	☐ Verbal ☐ Sign ☐ Speech generating device ☐ Gestures ☐ Other:________________________

Educational Background

Does your child attend school?	☐ No ☐ Yes School:____ Grade:____ Teacher's name:__________________________________ Teacher's email:__________________________________
Does your child receive the following therapies in school? Provide information for all that apply.	
Special education: ☐ No ☐ Yes Direct/indirect minutes per week:__________________ Teacher:____ Teacher's email:__________________________________ ***Please attach a copy of your child's IEP*** Occupational therapy: ☐ No ☐ Yes Direct/indirect minutes per week:__________________ Therapist:_______________________________________ Therapist's email:_________________________________	Physical therapy: ☐ No ☐ Yes Direct/indirect minutes per week:__________________ Therapist:_______________________________________ Therapist's email:_________________________________ Speech therapy: ☐ No ☐ Yes Direct/indirect minutes per week:__________________ Therapist:_______________________________________ Therapist's email:_________________________________ Other: ☐ No ☐ Yes Specialist:_______________________________________ Specialist's email:_________________________________
May we communicate with the school staff?	☐ No ☐ Yes
Does your child currently receive outpatient therapy services, or have they received them in the past? If so, please describe.	Clinic name:_____________________________________ Services (check all that apply): ☐ PT ☐ OT ☐ SP Time frame of services received:____________________ Clinic name:_____________________________________ Services (check all that apply): ☐ PT ☐ OT ☐ SP Time frame of services received:____________________

Family Information

Caregiver 1 Name: Relationship to child: Date of birth (mm/dd/yyyy): Occupation:	Caregiver 2 Name: Relationship to child: Date of birth (mm/dd/yyyy): Occupation:

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Other caregivers	Name: ______________________ ______________________ ______________________ Relationship to child: ______________________ ______________________ ______________________
Are primary caregivers:	☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Living together ☐ Remarried
Besides caregivers listed above, who lives in the home with the child? Please list names and dates of birth of children:	
Is the child adopted? If so, provide age adopted and birth location:	☐ No ☐ Yes, Age adopted:______ Birth location:________________________
Is the child in foster care? If so, provide the date of placement and pertinent information regarding biological parents.	☐ No ☐ Yes, Placement date:___/___/_____ Additional info:
Is there an immediate or extended family history of any of the following? Check all that apply:	☐ ADHD ☐ Dyslexia ☐ Autism/PDD ☐ Hearing Loss ☐ Stuttering ☐ Communication Disorders
Please indicate holidays your family observes.	☐ Valentine's Day ☐ Saint Patrick's Day ☐ Easter ☐ Halloween ☐ Thanksgiving ☐Christmas ☐ Hanukkah ☐ Kwanzaa ☐ Cinco de Mayo ☐ 4th of July ☐ Mother's Day ☐ Father's Day ☐ Ramadan ☐ Diwali ☐Additional:___________________________________

****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 allows us to be able to spend as much time as possible with your child during your scheduled time. It will help us complete the assessment process more accurately and completely.

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