Children's Therapy Center, Inc.

childrenstherapyctr.com

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Patient Case History Questionnaire

Patient's Name:_____ Birthdate:_____ Today's Date: _____

Child's gender: ☐ Male ☐ Female ☐ Prefer not to specify Person Completing Form: _____

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 & Language Therapy ☐Feeding Therapy
Explain your reasons for pursuing this evaluation and treatment priorities:	
Does your child have any medical diagnoses? ☐No ☐Yes, indicate date of diagnosis & name of provider who made diagnosis. 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, please explain	
Were drugs or medications taken during pregnancy? ☐ No ☐ Yes, please explain	
Was this pregnancy full term? ☐ No ☐ Yes Gestational age:	
Delivery: ☐ vaginal ☐ caesarian Hospital: _____ Birthing Center: _____ or Home Birth:_____	
Complications during delivery? ☐ No ☐ Yes, please explain	
Weight at time of delivery:	_____ pounds _____ ounces
Apgar scores (if known):	
Is the child born as a twin or multiple?	☐ No ☐ Yes, explain
Did your child require a stay in the NICU?	☐ No ☐ Yes, how long?
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 ☐Constipation issues ☐Sucking thumb/fingers/pacifier ☐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? ☐ No ☐ Yes

Does your child have a history of vision problems? ☐ No ☐ Yes, please describe

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? ☐ No ☐ Yes, please list

Provider & Specialty:_____ Provider & Specialty:_____

Clinic:_____ Clinic:_____

How often are they seen? _____ How often are they seen? _____

*provide additional info. in this space

Growth and Development

What age did your child…

Babble: _____

Roll from stomach to back: _____ Cruise furniture: _____ Speak first word: _____

Roll from back to stomach:_____ Walk independently: _____ Speak 2 word sentences: _____

Sit independently:_____ Use feeding utensils: _____ Toilet trained: _____

Belly crawl:_____ Drink from open cup: _____ Toilet trained through the night: _____

Crawl on hands/knees:_____ Dress independently: _____ Stand independently:_____

Check all of your child's current motor skills

☐Jump up & 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 ☐Usually happy ☐Frequent tantrums ☐Nervous habits/tics ☐Sensory seeking behaviors ☐Poor attention span

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 ☐ Have difficulty separating from caregivers
☐ Recognize danger ☐ Draw attention by pointing ☐ Understand praise/reward
☐ Participate in imaginative play ☐ Make eye contact ☐ Follow directions
☐ Show affection to familiar 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, please describe:
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, please describe:

Is your child on any medications? ☐ No ☐ Yes If yes, please list below.

Medication: _____
Dosage:_____
Purpose: _____
Date initially prescribed:_____

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Dosage:_____
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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, please describe
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(s) of communication? (Check all that apply)	☐ Verbal ☐ Sign ☐ Speech generating device ☐ Gestures ☐ Other:_____

Educational Background

Does your child attend school? ☐ No ☐ Yes,
School:_____ Teacher's name:_____
Grade:_____ 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:_____

Physical therapy: ☐ No ☐ Yes
Direct/indirect minutes per week:_____
Therapist:_____
Therapist's email:_____

Please attach a copy of your child's IEP

Occupational 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, please fill out consent and release form
Does your child currently receive *outpatient* therapy services, or have they received them in the past? ☐No ☐Yes, (☐currently or ☐previously) If yes, 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	
Primary Caregiver 1 Name: Relationship to child: Date of birth (mm/dd/yyyy): Occupation:	Primary caregiver 2 Name: Relationship to child: Date of birth (mm/dd/yyyy): Occupation:
Other caregivers: Please list their name(s) and 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?	☐ 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 ☐Migraines ☐Hearing Loss ☐Stuttering ☐Anxiety ☐ GERD ☐ Communication Disorders ☐ Vision impairment:(☐ *nearsighted,* ☐ *farsighted,* ☐ *color blindness*)	
Please indicate holidays your family observes. Check all that apply: ☐Valentine's Day ☐Easter ☐ 4th of July ☐Saint Patrick's Day ☐Cinco de Mayo ☐Mother's Day ☐Father's Day ☐ Halloween ☐ Thanksgiving ☐Christmas ☐ Hanukkah ☐ Kwanzaa ☐ Ramadan ☐ Diwali ☐Additional:	

Additional Information you'd like to share: _____

_____

***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.