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CHILD CASE HISTORY FORM

General Information:

Child's name: _____ Birth Date: _____ Today's date: _____
Primary address: _____ City/State: _____ Zip: _____

Guardian name: _____ Occupation: _____ Primary Caretaker? ☐yes ☐ no

☐ Mother ☐ Father ☐ grandmother ☐ grandfather ☐ Birth parent ☐ Step parent ☐ Adapted parent ☐ Other: _____

☒ Check preferred #: ☐ Cell: _____ ☐ Home: _____ ☐ Work: _____
Ok to text? ☐yes ☐no

e-mail: _____ address: _____
(if different than child's address)

Guardian name: _____ Occupation: _____ Primary Caretaker? ☐yes ☐ no

☐ Mother ☐ Father ☐ grandmother ☐ grandfather ☐ Birth parent ☐ Step parent ☐ Adapted parent ☐ Other: _____

☒ Check preferred #: ☐ Cell: _____ ☐ Home: _____ ☐ Work: _____
Ok to text? ☐yes ☐no

e-mail: _____ address: _____
(if different than child's address)

Additional names of caretakers with child during the week:

_____ ☐ Nanny ☐Grandparent ☐ Other: _____ Phone: _____

_____ ☐ Nanny ☐Grandparent ☐Other: _____ Phone: _____

Siblings:

Name: _____ DOB: _____ History of speech & language delay? ☐yes ☐ no

Name: _____ DOB: _____ History of speech & language delay? ☐yes ☐ no

Primary Language in home: _____ Secondary Language(s): _____

School Information:

School: _____ Teacher: _____ Grade: _____
Type of Classroom: _____
Therapies at school: ☐ speech ☐OT ☐PT ☐behavior ☐ vision ☐hearing ☐adaptive PE ☐ other: _____
Concerns about your child's school performance:

_____

Medical History:

Pediatrician: _____ Phone: _____ Address: _____

Neurologist: _____ Phone: _____ Address: _____

Other Specialist: _____ Phone: _____ Address: _____

Diagnosis: _____ DX given by: _____ Child's age or date when DX was given: _____

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Date of last hearing screening: _____ Results within normal limits? ☐yes ☐ no Chronic ear infections? ☐yes ☐ no PE tubes? ☐yes ☐ no Dates of PE tubes: _____

Results and date of vision screening/tests: _____

Medications / vitamins / herbal supplements: _____

_____

Allergies: _____

Food allergies, food restrictions, special diet: _____

Serious or recurrent illnesses: _____

Operations / accidents / hospitalizations: _____

_____

Has your child had the following:

☐ seizures ☐ adenoidectomy ☐ high fevers ☐ constipation ☐ all current vaccinations recommended by doctor

☐ pneumonia ☐ tonsillectomy ☐ feeding difficulties ☐ anxiety

☐head injury ☐ encephalitis ☐ sleeping difficulties ☐ behavioral problems

Comments: _____

Prenatal / birth history:

Full term? ☐yes ☐ no If no, How many weeks? _____ Was the labor: ☐ vaginal ☐ cesarean ☐ breech

Birth weight: _____ Birth height: _____ Multiple birth? ☐yes ☐ no Did baby come home with family? ☐yes ☐ no

Illnesses or accidents during pregnancy: _____

Labor complications: _____

Mother's age when she gave birth: _____ Use of alcohol, tobacco or medications during pregnancy? ☐yes ☐ no

Any injuries to mother or baby during birth? ☐yes ☐ no Explain: _____

Developmental History:
List ages of when your child did the following: (If you can't remember age then estimate or state if it was delayed / typical)
Sat independently: _____ Crawled: _____ Walked: _____
Dressed self: _____ Tied shoes: _____ Hand dominance: ☐ Right Handed ☐ Left Handed ☐ Both
Toilet Trained: _____ Weaned from bottle/breast: _____ Fed self independently: _____
Problem with: ☐ Chewing ☐Swallowing ☐Drinking ☐ Drooling ☐ Thumb/finger sucking/pacifier Picky eater? ☐yes ☐ no
What does your child like to eat?_____
What does your child avoid eating? _____
Do you have sensory concerns for your child? ☐yes ☐ no Explain: _____
Please list any gross/fine motor limitations / concerns: _____

Speech and Language History:
Babbled: _____ First word: _____ Two word combinations: _____
Three word combinations _____ Complete sentences: _____
Simple conversational exchanges: _____ Retold event or story: _____
If your child expresses fewer than 20 words please list: _____

_____

If your child is nonverbal or has limited verbal skills please indicate forms of communication:
☐ pointing ☐ gesturing ☐ sign language ☐Picture exchange / PECS ☐ AAC -- Device type: _____
If your child is verbal what percentage of his/her speech do you understand …
With the context known? ☐85-100% ☐85-70% ☐70-55% ☐ 55-40% ☐40-25% ☐ less than 25%
With the context unknown? ☐85-100% ☐85-70% ☐70-55% ☐ 55-40% ☐40-25% ☐ less than 25%
How much do other people understand your child? ☐85-100% ☐85-70% ☐70-55% ☐ 55-40% ☐40-25% ☐ less than 25%
Please list sounds or words that your child cannot say correctly and explain if necessary:
_____

If your child stutters – what age did it begin and explain what disfluencies you hear: _____

_____

Private Therapy Information (therapy outside of school therapy):

Service Type	Therapist	Agency/Location	Frequency of Treatment	Date Therapy Began
Speech				
Occupational Therapy				
Physical Therapy				
Behavior ABA				
Floortime				
Other				

List other extracurricular activities your child is involved in: _____

Social/ Pragmatics:
Do you have concerns about your child's eye contact / joint attention? ☐yes ☐ no Explain: _____

Briefly describe your child's play skills: _____

Does your child make friends easily? ☐yes ☐ no Explain: _____

Any other social concerns: _____

Additional Information:
Explain your child's strengths: _____

_____

Please list your concerns for your child: _____

_____

What goals do you have for your child? _____

_____

If your child has been in therapy in the past, what worked well for your child? _____

_____

What didn't work well? _____

What motivates your child? _____

_____

Please list any additional information that would be helpful for me to know.

_____

_____

_____

I may need access to wireless internet for therapy purposes on my iPad or laptop. If you have wireless internet and consent for me using it for therapy purposes please fill out the information below:

Network name: _____ Password: _____