

Child Case History Form

General Information

Child's name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ Zip: _____
Parent(s)/Guardian(s): _____
Referred By: _____ Phone: _____
Physician: _____ Phone: _____
Brothers and Sisters (include names and ages):

Mother's occupation: _____
Father's occupation: _____

What goals would you like to see achieved through speech therapy, occupational therapy or physical therapy services?

What are your child's hobbies and favorite interests?

Please provide any additional information that you believe would help the therapist get to know your child.

Prenatal and Birth History

Adopted: Yes No

If so, please list any factors that may have contributed to your child's development.

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Was the delivery premature? If so, how many weeks?

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma _____ High Fever _____

Draining Ear _____ Seizures _____
Ear Infections _____ Other _____

Has the child had any surgeries? If yes, what type and when (e.g., Tonsillectomy, Adenoidectomy, etc.)?

Describe any major accidents or hospitalizations.

Has your child had a vision exam? If yes, what were the results?

Has your child had a hearing exam? If yes, what were the results?

Is your child currently taking any medications?

Does your child have any allergies?

Developmental History

At what age did your child achieve the following milestones? Some of the milestones may not be applicable to your child at this time.

Hold head up _____

Roll over _____

Sit independently _____

Crawl on hands and knees _____

Cruise around furniture _____

Walk independently _____

Drink from an open cup _____

Eat solid food _____

Spoon feed independently _____

Tying shoes _____

Toilet trained _____

Use single words (e.g., *no, mom, doggie*, etc.) _____

Combine words (e.g., *me go, daddy shoe*, etc.) _____

Name simple objects (e.g., *dog, car, tree*, etc.) _____

Use simple questions (e.g., *Where's doggie?* etc.) _____

Engage in a conversation: _____

Educational History

School: _____ Grade: _____

Teacher(s): _____

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)?

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Activities of Daily Living (Write N/A if no concerns in this area) _____

Is your child able to perform the following self-help skills?

Dresses self _____

Undresses self _____

Toileting _____

Brushes teeth _____

Washes hands _____

Feeds self _____

Drinks from an open cup _____

Zippers _____

Buttons _____

Snaps _____

Puts on shoes _____

Puts on socks _____

Ties shoes _____

Sensory History (Write N/A if no concerns in this area) _____

Does your child become upset when getting messy or dirty (e.g., dirt, glue, finger painting, etc.)?

Does your child seem to crave jumping or falling into objects or people?

Does your child become upset when hearing an unexpected or loud sound?

Does your child have difficulty discriminating between the size and shape of an object?

Does your child seem overly cautious on playground equipment?

Gross Motor Skills/Motor Planning (Write N/A if no concerns in this area) _____

Is your child able to...?

Hop/balance on one foot?

Skip?

Climb on or over objects?

Jump with both feet together?

Ride a tricycle?

Ride a bicycle without training wheels?

Jump rope?

Kick a ball?

Throw/catch a ball?

Dribble a ball?

Pump self on a swing?

Ascend and descend stairs?

Does your child...

Have slow and deliberate movements with motor activities?

Move quickly and loose control?

Seem uncoordinated or awkward?

Have difficulty running?

Have difficulty learning new skills?

Fine Motor Skills (Write N/A if no concerns in this area) _____

Is your child able to...?

Cut with scissors?

Color inside the lines?

Play with manipulative toys?

Demonstrate a consistent hand preference?

Identify left and right hands?

Does your child...

Have difficulty holding a pencil correctly?

Reverse letters when writing?

Have difficulty with spacing and sizing of letters?

Express fatigue when writing?

Become easily frustrated when writing?

Have difficulty copying shapes?

Have difficulty remaining on a line when writing?

Feeding/Oral Motor (Write N/A if no concerns in this area) _____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, choking, drooling, chewing, etc.)? If yes, please describe.

Have there ever been any concerns with the intake of liquids (e.g., choking, aspiration)?

Are your child's food preferences a concern?

Does your child prefer certain textures (e.g., crunchy, soft, chewy, etc.) or flavors (e.g., sweet, salty, sour, etc.) of food?

What are some of the typical foods in your child's diet?

Does your child gag when eating certain foods or textures?

Does your child chew on non-food objects?

Does your child use a pacifier or suck their thumb?

Does your child become upset with their teeth being brushed?

Does your child require a special diet?

Does your child have a history of reflux?

Speech/Language (Write N/A if no concerns in this area) _____

Describe the child's speech-language problem.

How does the child usually communicate (gestures, single words, short phrases, sentences)?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

Person completing form: _____

Relationship to child: _____

Signed: _____ Date: _____