Case History Form

Patient Information

First Name: _____ **Last Name:** _____

Nickname: _____ **Gender:** _____

Birthdate: _____ **Occupation Organization / School:** _____

School Grade: _____

What is your child's primary language?: _____ **What language(s) does your child speak?:** _____

What are your child's pronouns?: _____

Caregiver Information

Contact #1

Full Name: _____ **Address:** _____

City: _____ **State:** _____

Zip Code: _____ **Email:** _____

Cell #: _____

Contact #2

Full Name: _____ **Address:** _____

City: _____ **State:** _____

Zip Code: _____ **Email:** _____

Cell #: _____

Additional phone numbers or emails relevant to this patient and outgoing information. : _____

Select the payer. : _____

Select the evaluation(s) you are seeking.: _____

Please list which evaluations you are seeking and describe why.:

_____

_____

_____

_____

List preferred times for weekly therapy services. Please note: times cannot be guaranteed.:

_____

_____

_____

_____

Check any practitioners your child has previously received services or an evaluation from.

Practitioner	Services	Explanation
Occupational Therapist		
Speech Therapist		
Physical Therapist		
Vision Specialist		
Child Psychologist/Psychiatrist		
Audiologist		
Behavioral Therapist (ABA)		
Special Education Teacher		
Pediatric Gastroenterologist		
Otolaryngologist (Ear, Nose, & Throat)		
Other		

For any practitioners identified above, please list the specialist's conclusions or suggestions.:

Provide the names and relationships of individuals currently residing in your child's household, including parents (adoptive or birth), caregivers, siblings (along with their ages), and other relatives.:

What language(s) are spoken within the home?: _____

Birth History

What was the mother's general health during pregnancy? List any illness, accidents, medications, etc. :

Length of Pregnancy.: _____ **Birth Weight.:** _____

Type of Delivery.: _____ **Length of Labor.:** _____

Were there any additional concerns or challenges during the birth?:

What was the child's general condition at birth?:

Did the child experience any early feeding, swallowing, or motor concerns? :

Medical History

Does your child have any medical diagnoses? :

Has your child experienced any past concerns related to growth, height, or meeting expected weight?:

List any medications your child is currently taking.:

List any known allergies.:

Select any of the following conditions your child has a history with. :

For any conditions selected above, please include a brief explanation.:

Describe any major accidents or hospitalizations.:

Has your child's vision been tested previously? If yes, when and what were the results? **Has your child's hearing been tested previously? If yes, when and what were th**

List any negative reactions to medications.:

Select any conditions of note among the child's family and close relatives.:

For any conditions selected above, please include a brief explanation.:

Developmental History

List the approximate age (preferably in months) your child met the below milestones. Your best guess is appropriate.

Milestone	Approximate Age
Cried Normally (to communicate pain, fear, discomfort, loneliness)	
Coo/Babbled	
Held Head Up	
Sat Alone	
Responded to Name	
Crawled	
Imitated Sounds	
Used Jargon*	
Ate Solid Foods	
Said First Word	
Walked Alone	
Fed Self	
Said 2 Words Together	
Jumped with Two Feet	
Ran	
Used Short Sentences	
Toilet-Trained	
Rolling	
Pull to Stand	
Cruising (walking side to side, holding on to item)	

*Jargon: words that are not understandable, but said in "sentences," where the child's inflections let you know that he/she is "saying something"

Describe your child's crawling style.: _____

How did your child tolerate tummy time?: _____

Current Level of Function

What are your child's preferred activities or toys?:

_____

_____

_____

_____

Describe your child's strengths and recent accomplishments.:

_____

_____

_____

_____

What areas/skills do you see as difficult for your child compared to their peers?:

How does your child interact with others?:

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

Give two to three examples of your child's comments that are typical at this time. :

Describe your child's gross motor skills while walking, running, climbing, etc. :

Describe your child's fine mot skills while attempting to color, draw, cut with scissors, etc. :

Describe your child's current sleep patterns and any challenges or concerns.:

How is your child doing academically (or pre-academically)?:

List any special services your child receives at school. :

List any extracurricular activities your child participates in. :

Select which of the following are challenging for your child to complete.:

Select all of the following that describe your child.

:

Provide any additional information that might be helpful in the evaluation or in our work with your child.: