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Therapy Connections, LLC

Case History Form

Please fill out this form as completely as you can. Your therapist may ask you additional questions to clarify or expand information.

Child's Information

Child's Name: _____Date of Birth____/_____/_____

Physician: _____Phone: _____Fax:_____

Referred by: _____Phone: _____Fax:_____

Reason for Referral: _____

Form is being completed by: _____

Mother's Name: _____

Address: _____
Street Address City State Zip

Telephone Number: **(**_____**)** _____Cell Phone Number: (____)_____

Email Address:_____

Father's Name: _____

Address: _____
Street Address City State Zip

Telephone Number: **(**_____**)** _____Cell Phone Number: (____) _____

Email Address: _____

Chief Complaint:

What are your main concerns with your child: Please include academic, personal and social concerns _____

_____

_____

_____

Gestation History

Child was born: full-term____ premature____ How many weeks?_____

Delivery: vaginal _____ forceps _____ vacuum _____C-section____ Breech____ Length of labor_____

Medications required during pregnancy_____

_____

Prenatal exposure to environmental toxins, drugs or high temperatures:_____

_____

Were there any complications during pregnancy or at the time of birth? _____

_____

Were excessive ultra sounds performed during the pregnancy? _____

_____

Was your child placed in the Intensive Care Unit?_____ If so, how long?_____

Please describe any other prenatal medical problems or complications at birth: _____

_____

Describe your experience during labor and delivery _____

More specifically:

	Yes	No	Comments
Were pregnancies complicated	____	____	_____
High forceps required	____	____	_____
Caesarean birth (reason)	____	____	_____
Birth weight	____	____	_____
APGAR rating	____	____	_____
Required special treatment (oxygen, jaundice, etc.)	____	____	_____
Did the newborn have immediate physical contact with the mother	____	____	_____

Going back to the first two years of the child's life, what type of baby were they? (feeding, sleeping, activity level)

	Yes	No	Comments
Extended separations during first	____	____	_____
Specific health problems this period	____	____	_____
Thumb sucking (until what age)	____	____	_____
Feeding or sleeping problems	____	____	_____

Medical History

Diagnosis, if any: _____

Allergies: _____

Medical Precautions: _____

Dietary Restrictions: _____

Is there a history of a serious accident/injury Yes_____ No_____

Please check all that apply to your child:

___Hearing aids ___Hearing difficulty ___Ear Tubes ___Chronic ear infections
___Vision difficulty ___Vision testing ___Glasses ___G-tube ___C-Line
___ Asthma ___ Bronchitis ___Convulsions ___Epilepsy ___Skin Problems
___Nightmares ___Fitful Sleep ___Bedwetting ___Nail Biting ___Brace
___Adaptive utensils ___Other _____

Is there any history of learning difficulties in the family or either parents family_____
_____

Is there a history of or diagnosis of a learning disability _____
_____
_____

Has the child been diagnosed with ADD/ADHD or Autism Spectrum Disorder _____
_____

When was the last time his/her eyesight was tested? Please list any difficulty _____
_____

List any information regarding ear infections, enlarged tonsils or adenoids, mouth breathing _____
_____

Does your child sleep well at night _____
_____

Has your child experienced any problems with hearing (operations, infections, tubes)?

Ear infections seldom ____ sometimes ____ often ____
Mild ____ moderate ____ severe ____

Are there any current hearing problems of which you are aware?_____

Is your child in good general health at the present time?_____

When was your child's most recent medical check-up?

Date_____ Doctor's Name_____

Additional Comments: _____
_____
_____

Surgical History

Surgical Procedures: _____

_____

Hospitalizations: No _____ Yes_____ If yes, please describe_____

_____

_____

Medications: _____

_____

Developmental Milestones – (mark approximate month)

Rolled over_____ Babbled_____ Said first word_____ Walked alone_____
Crawled_____ Sat alone_____ Pulled to a stand_____ Used spoon_____
Drank from a cup_____ Stood alone_____ Toilet trained_____ Dressed self _____
Combine simple phrases _____ Stuttering_____

General co-ordination poor____ fair____ good____ excellent____

General balance: poor____ fair____ good____ excellent____

Describe your child's motor development Normal_____ Delayed_____ Advanced_____

Hand preference: Right____ Mixed____ Left____

Current physical limitations: _____

_____

Tell about babbling/cooing behavior - Did it seem normal? Little or a lot of sound-play as a baby: _____

_____

Please give examples of common sentences your child says: _____

_____

Is your child easy to understand by family? Do others (friends, playmates) understand his/her speech: _____

_____

What percentage of your child's speech do you understand _____% Strangers_____%

Any history of cleft lip/palate or dental anomalies_____

Nutritional Concerns: _____

Is your child eating a good variety of foods? ___Yes ___No

Food Preferences/Dislikes (Taste, Texture) _____

_____

Any difficulties with early feeding? _____

Additional comments: _____

_____

_____

Home Environment

Child lives with: ___ Biological Parent(s) ___ Adoptive Parent(s) ___Legal Guardian(s)

___Grandparent(s) ___Other_____

List siblings and ages _____

_____

Pets: _____

What, if any, stresses are affecting your family at this time? _____

_____

Which language (s) is spoken at home?_____

Additional Comments: _____

_____

At home, how would you describe their general adaptability ___Poor ___Fair ___Good ___Excellent

_____

_____

Have there been any major moves? (City to city, state to state, country to country) _____

_____

Treatment History

Previous Therapy : ___OT ___ PT ___Speech ___Special Education ___Behavior Intervention

___Medical ___Audiological ___Sensory Integration ___Educational

Previous psychological evaluation: No ____ Yes_____ If yes, please describe_____

_____

Comments:_____

_____

School History

School/Educational program currently attending and grade:_____

In general, how would you describe your child's experience/learning at school from kindergarten to the present time? _____

_____

How did your child adapt to the first day(s) at school or pre-school

Mostly positive_____ Mixed_____ Mostly negative_____

How old were they_____ How much time did they attend per week? _____

Has there been remedial help given outside the school system? Yes_____ No_____

If yes, describe:_____

_____

Special services received in school: ___OT ___ PT ___Speech ___ Special Education ___Behavior Intervention

Additional Comments:_____

_____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor skills_____ Social abilities _____ Self-help skills_____ Learning abilities _____

Social/ Emotional Development

Does your child interact well with others ____Yes ____ No

Does your child have any trouble making friends? ____ Yes ____ No

Does your child have difficulty calming when upset ___Yes ____ No

Fears and coping behaviors: _____

_____

What kind of interests and activities does your child have (hobbies, sports, clubs) _____

_____

How would you describe your child?_____

_____

What are your child's strengths?_____

_____

What are your child's weaknesses? _____

Have there been any specific behavior problems in the course of your child's development? _____

_____

With adults? _____

What does your child find enjoyable? _____

_____

Additional comments: _____

_____

Behavior

___ Cries often	___ Dislikes hair brushing	___ Clumsy	___ Dislikes tooth brushing
___ Anxious	___ Rocks self	___ Mouths objects	___ Poor attention span
___ Sensitive to sound	___ Trouble with transition	___ Crave jumping	___ Crave crash play
___ Avoids touch others	___ Trouble attending to task	___ Dislikes playground	___ Picky Eater
___ Gagging	___ Choking	___ Reflux	___ Excessive Drooling
___ Food Stuffing	___ Pocketing/holding	___ Puree foods	___ Solid Foods
___ Cup Drinking	___ Straw Drinking	___ Self-feeding	

Please add any other comments you might have regarding your child's behavior and character _____

_____

_____

Additional Comments _____

_____

_____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

_____ _____

Signature Date