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CHILD THERAPY CASE HISTORY FORM

The Clinical Services Department at United Rehabilitation Services requests this information for the purpose of completing your evaluation. Completion of this form is required prior to your scheduled evaluation.

GENERAL INFORMATION

Child's Name:	Date of Birth:	Age:	Today's Date:
Referred By:	Physician:		Name of person completing form:

What services are you here for?

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Speech Therapy / Hearing Screening

What are your main concerns?

- Fine motor (e.g. handwriting, buttoning)
- Gross motor (e.g. walking, kicking ball)
- Speech
- Language
- Mobility
- Feeding
- Behavior

THERAPY PRECAUTIONS (Please list)

Does your child have food allergies? _____
 Does your child have any movement restrictions? _____
 Are there any other precautions that we should know about? _____
 Does your child have any other allergies? _____

FAMILY HISTORY

Father's name:	Age:	Occupation:
Mother's name:	Age:	Occupation:
Is he/she adopted? Yes No If so, at what age?		
Parent's marital status: Married Living Together Separated Divorced Remarried		
Who lives in this house with this child?		
Have there been any of the following in your immediate or extended family?		
<input type="radio"/> ADHD <input type="radio"/> Learning Disability <input type="radio"/> Autism / PDD <input type="radio"/> Hearing loss <input type="radio"/> Stuttering		

PREGNANCY AND BIRTH HISTORY

	Yes	No	Comments
Were there any complications during the pregnancy?			
Was the pregnancy full-term?			
Were any drugs or medications taken during the pregnancy?			
Was labor and delivery normal?			
Please list birthweight and length			

MEDICAL HISTORY

Has your child had any of the following?

- Meningitis
- Chicken pox
- Seizures
- Head injury / trauma
- Allergies
- Frequent ear infections
- P.E. ear tubes inserted
- Excessive vomiting or reflux
- Cleft palate
- Vision problems
- Other (please list / explain)

Please explain _____

Is your child taking any medications? Yes No (If yes, please list)

Medication

Reason taken

_____	_____
_____	_____
_____	_____
_____	_____

GROWTH AND DEVELOPMENT

At what age did your child:

Roll over from stomach to back? _____
 Roll from back to stomach? _____
 Sit independently? _____
 Crawl? _____
 Walk holding onto furniture? _____
 Walk independently? _____
 Speak first word? _____
 Speak in 2-word sentences? _____
 Drink from a cup? _____
 Use a spoon? _____
 Dress independently? _____
 Toilet train? _____

Which of the following is your child able to do?

- Jump up and down Hop on one foot Skip Catch a ball Kick a ball Climb / descend stairs

Please describe your child: (circle)

- | | | | |
|-----------------------|-------------------------|-------------------------------|----------|
| mostly quiet | tires easily | talks constantly | clumsy |
| impulsive | overly active | overreacts frequently | happy |
| has temper tantrums | has poor attention span | gets frustrated easily | shy |
| difficulty separating | has nervous habits | has unusual fears | restless |
| avoids touch | craves touch | difficulty learning new tasks | stubborn |

Other (please explain) _____

COMMUNICATION HISTORY

Please describe any communication difficulties _____

When was the problem first noticed? _____

Has there been a change in your child's communication in the last 6 months? Yes No If yes, please explain:

How does your child communicate at home? (e.g. signs, PECs, verbal, augmentative communication) _____

Was there ever a period when speech or language development seemed to stop? Yes No If yes, please explain:

How many words are in your child's vocabulary? (please circle)

Speaking vocabulary (expressive)	under 25	25-75	over 75
Words they understand (receptive)	under 25	25-75	over 75

Does your child: (please circle)

Understand and follow simple directions?	Yes	No
Identify body parts?	Yes	No
Recognize pictures of common objects?	Yes	No
Turn his/her head when name is called?	Yes	No
Communicate with intent?	Yes	No
Answer yes/no questions?	Yes	No
Answer "wh" questions?	Yes	No
Have hearing loss?	Yes	No
Respond to loud sounds?	Yes	No
Respond to soft sounds?	Yes	No

Has your child had a hearing evaluation? Yes No

If yes, when? _____

Where? _____

By whom? _____

Has your child had:

Changes in hearing during the last 6 months?	Yes	No
Changes in hearing in the last year?	Yes	No
Balance problems?	Yes	No
Dizziness?	Yes	No
Hearing better on some days rather than others?	Yes	No
Ringing or noise in the ears?	Yes	No
Nausea?	Yes	No
Discharge from the ears?	Yes	No
Pain in the ears?	Yes	No

What languages are spoken in the home? _____

EDUCATIONAL BACKGROUND

Does your child attend school? Yes No

If so, where? _____

What grade is he/she in? _____

Has your child ever repeated a grade? Yes No If so, what grade? _____

Does your child receive special education or therapy services in school? Yes No

If so, what services?

OT	PT	Speech	Other (please explain) _____
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How often? _____

How long? _____

Individual / group? _____

Has your child received therapy anywhere else? Yes No

If so, what therapies? _____

Where? _____

By whom? _____

Are there any religious or cultural issues that we should be aware of regarding your child's evaluation? _____

What therapy goals has your child focused on? _____

What are your child's favorite play activities? _____

What goals are you seeking for your child? _____

Please add any additional information that you feel will help us to understand your child and your concerns _____
