Creative Speech Solutions, LLC

Pediatric Therapy Center

OCCUPATIONAL THERAPY CASE HISTORY FORM

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD HERE

Date____________________
Person filling out this questionnaire____________________________
Relationship to child ______________________________________

IDENTIFYING INFORMATION

Name of child____
Nickname____
Date of Birth __________________ Child's age ________________
Address____
City__________________________County__________________ State____________Zip_______________
Home#________________________Cell# _________________________Work#_____________________
Alternate phone number(s) ____
Email address: ____
I prefer to be contacted by: email_____ cell phone______ work phone______ home phone________

	Name	Age	Occupation	Education
Parent 1:				
Parent 2:				

If the address of either parent is different from that of the child, please indicate:
____

Other children in the family:

Name	Sex	Age	School-Grade

Who can we thank for telling you about our practice? ___________________________________
Child's Doctor:_________________________________Address_________________________________
____
Do you want a copy of our report sent to your child's doctor? Yes____ No____
To what other professional persons or agencies do you want a report sent?__________________
____
____
____

STATEMENT OF THE PROBLEM

Describe what problem(s) your child is having with motor development, sensory processing, or behavior:

____

____

____

Does your child have any speech, language or hearing disorders or challenges? Yes____ No___

If yes, please describe ____

____

____

____

List any other concerns you have regarding your child's development:

____

____

____

Does your child have a formal diagnosis? Yes____ No____ If yes, what is it?__________________________

____

When was it made?______________________________By whom?________________________________

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

At what age did the child say his or her first word(s)?____________________________________

Did speech learning ever seem to stop for a period of time? Yes____ No______

If yes, explain ____

Does your child talk a lot_____ occasionally_______ never______

Does the child most frequently use sounds________ single words_________ 2-word sentences______________

3-word sentences_______ more than 3-word sentences_________

Is your child difficult to understand? Yes____ No_______ If yes, explain____________________________

____

Does the child seem to understand what you say to him or her? Yes____ No___

If no, explain ____

Does your child consistently answer to his/her name? Yes____ No______

Does your child make appropriate eye contact with adults? Yes____ No____ Other children? Yes____ No___

Does your child follow simple commands? Yes____ No______

Please describe/give examples:____

Does your child ever have trouble remembering what you have told him or her? Yes____ No_______

If yes, explain?____

DEVELOPMENTAL HISTORY

Check which is applicable: This is our biological_________ foster___________ adopted___________ child

Did the mother have medical problems during the pregnancy? Yes____ No______

If yes, please describe, including medical attention:_____________________________________

____

____

Did the mother take any prescription and/or nonprescription medication during this pregnancy? Yes____ No__
If yes, what kind(s)?____
Was the child full-term? Yes____ No_____ If no, what was the gestational age?______________________
Was the delivery normal? Yes____ No____ If no, explain ____
____
Caesarian? Yes____ No_____ If yes, reason?____
How long were the mother and child in the hospital?____
Child's weight at birth?__________ Any birth injuries?___________ Was the child an RH baby?_________
What special medication attention or treatment did the child receive at birth, if any?__________________
____
Were there any feeding difficulties during infancy Yes____ No__
If yes, describe____
____
Did the child have difficulty transitioning to different food textures? Yes____ No____
If yes, explain____
____
Does your child have a limited diet due to "picky eating?" Yes____ No_____
If yes, describe____
____
____
Does your child have any food allergies? Yes____ No____
If yes please list:____
____
____
Check all that apply: Child finger feeds______ uses a fork_____ a spoon_____ an open cup____ a straw____
Is adult assistance needed with feeding? Yes____ No____
If yes, explain____
Has he/she ever choked on solid foods? Yes____ No_____ Does your child cough on liquids? Yes_____ No____
Can your child chew well? Yes_____ No_____ Does he/she drool? Yes_____ No___ If yes, when? ___________
Did child use pacifier? Yes_____ No___ If yes, age weaned from pacifier__________________
Does child continue to mouthe objects? Yes_____ No_____
Did child suck his/her thumb/fingers? Yes_____ No____ If yes, until when? __________________________
Does your child suck on his/her hair/clothing/blanket/etc? Yes____ No_____ If yes, what?______________
Does child resist tooth brushing? Yes_____ No_______ Does he/she like taking a bath? Yes_____ No_______
Swings? Yes_____ No_____ Parties? Yes_____ No_____ Rough housing? Yes_____ No___
Child prefers to primarily play: alone______ with other children________ with older children________ with younger children___________ with adults________
Is your child overly sensitive to loud sounds? Yes_____ No______ Bright lights? Yes_____ No_______
Tags on clothing? Yes____ No_____
Does your child have difficulty falling asleep? Yes_____ No_______ Staying asleep? Yes_____ No_____
Give ages at which the following first occurred:
Sat up_____________ Crawled____________ Stood___________Walked _____________ Ran______________
Bladder trained_________________ Bowel trained_____________________ Night trained _______________

Which hand does the child use more frequently? Right_________ Left_______ No preference_________
Check all that your child can do independently:
button_____ zip_____ put on a jacket___ pants_____ shirt____ socks____ shoes_____

FAMILY HISTORY

Are there any members of your immediate family that have been diagnosed with any of the following:
(Please indicate "F" for father, "M" for mother, or "S" for sibling)

________ learning disability
________ dyslexia
________ speech and language delay/disorder
________ sensory processing disorder
________ auditory processing disorder
________ ADD/ADHD
________ delayed motor skill development
________ autistic spectrum disorder/PDD
________ hypotonia
________ other, please explain ____

MEDICAL HISTORY

Does your child have a history of ear infections? Yes____ No____If yes, please indicate age, recurrence, and treatment ____
____
____

Does your child have a history of seizures? Yes____ No____If yes, please indicate age, recurrence, and treatment ____
____
____

Describe any other illnesses, accidents, injuries, and hospitalizations of the child (include child's age)
____
____
____

If your child underwent any surgery, please describe (include date of surgery and surgeon's name)
____
____
____

Is the child's health good?______ Fair______ Poor______ Is the child now under medical treatment or on medication? Yes_____No______ If yes please explain:____
____
____

MEDICAL EXAMINATION HISTORY

Month/year of last PHYSICAL EXAM________________________Doctor_____________________________

Results:____

Month/year of last VISION TEST_________________________ Doctor_____________________________

Results:____

Month/year of last HEARING TEST________________________Doctor_____________________________

Results:____

Did/does child wear a hearing aid? Yes____No____ Glasses? Yes____No_____

If yes, explain:____

____

Dates of other pertinent medical examinations (e.g., neurological, psychological and ENT):

Date____________________Doctor________________________ Results:____________________________

____

Date____________________Doctor________________________ Results:____________________________

____

Date____________________Doctor________________________ Results:____________________________

____

EDUCATIONAL HISTORY

Does your child attend? Daycare________ Preschool_________ Kindergarten_________Grade School ______

Name of School ____ Grade/Level ______________________

In school, does he/she do: average ________ below average ________ above average _______work

What are the child's best subjects?____

Has he or she repeated a grade? Yes____No_____If yes, which one(s)?_______________________________

What is your impression of your child's learning abilities?____

____

What is your impression of your child's social skills? ____

____

____

Does your child display any behavioral or attentional issues at school? ________________________________

____

____

____

Does your child participate in extracurricular activities? Yes____ No____If yes, please list, below

____

____

____

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that the child is receiving/has received.

Type of Therapy	Therapist	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)