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)