CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

OCCUPATIONAL THERAPY CASE HISTORY FORM

Date_____

Person filling out this questionnaire_____

Relationship to child _____

Child's Doctor:_____

Doctor's Address_____

_____

Do you want a copy of our report sent to the pediatrician? Yes___ No___

To what other professional persons or agencies do you want a report sent (please provide name/address)?

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD HERE

_____

_____

Who can we thank for telling you about our practice? _____

IDENTIFYING INFORMATION

Name of child_____Nickname_____

Date of Birth _____ Child's age _____

Address_____

City_____State_____Zip_____

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

_____

Home#_____Cell#_____Work#_____

Alternate phone #_____Email address _____

I prefer to be contacted by: email_____ cell phone_____ work phone_____ home phone_____

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?_____

FAMILY HISTORY

	Name	Age	Occupation	Education
Parent 1:				
Parent 2:				

Other children in the family:

Name	Sex	Age	School-Grade

Have any members of your immediate family been diagnosed with any of the following:

(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

_____ autistic spectrum disorder/PDD

_____hypotonia

_____ delayed motor skill development

_____ other, please explain _____

BIRTH 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 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?_____

Were there complications during delivery? Yes_____ No_____ If yes, 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? Yes_____ No____ If yes, explain _____

_____Was the child an RH baby?_____

What special medication attention or treatment did the child receive at birth, if any?_____

_____

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 (include child's age).

_____

_____

_____

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

_____

_____

_____

Child's health is 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:_____

_____

FEEDING HISTORY

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:_____

_____

_____

Does your child have any known gastrointestinal issues? Yes____ No____If yes, explain:

_____

_____

Has he/she ever choked on solid foods? Yes_____ No____Does child cough on liquids? Yes____ No_____

Can child chew well? Yes_____No_____

DEVELOPMENTAL HISTORY

Give ages at which the following first occurred:

Sat up_____Crawled_____Stood_____Walked_____ Ran_____

Did/does child use pacifier? Yes____ No____If yes, age weaned from pacifier_____

Does child continue to mouthe objects? Yes_____ No_____

Does he/she drool? Yes____ No____If yes, when? _____

Did/does child suck thumb/fingers? Yes_____ No____If yes, until when? _____

Does child suck on hair/clothing/blanket/etc? Yes____ No____If yes, what?_____

Does child enjoy taking a bath? Yes____ No____Swings? Yes____ No____Parties? Yes____ No_____

Rough housing? Yes_____ No_____

Does child resist tooth brushing? Yes_____ No_____

Child prefers to primarily play alone_____with other children_____with older children_____

with younger children_____with adults _____

Is child overly sensitive to loud sounds? Yes____No____Bright lights? Yes___ No___Tags? Yes___ No____

Does your child have difficulty falling asleep? Yes_____ No_____ Staying asleep? Yes_____ No_____

Check all that apply: Child finger feeds_____ uses fork_____spoon_____open cup_____straw_____

Is adult assistance needed with feeding? Yes____ No_____If yes, explain_____

_____

Is the child potty trained? Yes _____ No _____If yes, at what age was he/she:

Bladder trained_____ Bowel trained_____Night trained _____

Check all that child can do independently:

Put on jacket_____pants_____shirt_____socks_____shoes _____

Button_____zip_____tie shoes_____

Which hand does the child use more frequently? Right_____Left_____No preference_____

Describe any OT or PT that the child is receiving/has received.

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

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Child babbled during the first 6 months? Yes___ No___At what age did child say first word?_____

What were the child's first words?_____

_____

Did the child keep adding words once he/she started to talk? Yes____ No____If no, explain:

_____

At what age did the child begin using 2 and 3 word phrases/sentences?_____

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 prefer to talk _____gesture_____talk and gesture_____

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?_____

_____

Describe any speech-language, hearing, feeding, or social skills therapy that the child is receiving/has received.

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

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/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? Yes_____No_____If yes, explain:

_____

_____

_____

Does your child participate in extracurricular activities? Yes_____No _____If yes, please list, below:

_____

_____

_____

Describe any psychological, special education services, tutoring that the child is receiving/has received.

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