CASE HISTORY FORM

Date: ___________________

Person filling out this form: ______________________ Relationship to child: ________

Identifying Information

Child's name: ____

Birth date: _______________________ Age: ______________ Gender: F M

Parents or Guardians: ____

Phone: ____
(home) (cell) (work)

Email: ____

Address:____

City: ___________________________ State: __________ ZIP: ___________________

History of Problem

Reason for referral: ____

Describe present problem: ____

Who noted present problem? ____

When? ____

What is your child's reaction to the problem? __________________________________

Any previous assessments? N Y Where? _____________________________

By whom? _____________________________ What kind? _______________________

What were the results? ____

Any previous therapy? Y N Where? ___________________________________

With whom? ____

Health History/Birth History

What was the length of the pregnancy? ____

Were there any illness or accidents during pregnancy? (explain) ____________________

Mother's health at time of pregnancy and birth was: ______________________________

Allergies? (Describe) ____

Any other serious or recurrent illnesses? _______________________________________

Any operations? / Any accidents? ____

Any medications? (Past) ___________________ (Current) ________________________

Vision problems? ____________________ Treatment: ___________________________

Hearing difficulties? __________________ Treatment: ___________________________

Dental problems? _____________________ Treatment: __________________________

Other Medical History: ________________ Treatment: __________________________

Developmental History

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed):

sat up alone _________crawled __________walked _________ toilet trained______

dressed self _________ tied shoes ________fed self independently ___________

Is the child left or right handed? Left Right

Attention span: for self-directed activities ________ for adult-directed activities: ______

Eating and sleeping patterns: ____

Language Development

Language(s) spoken in home: ____

Age when your child spoke first word: ___________ combined words: ______________

Spoke in sentences: ________ What was your child's first word(s)? _________________

Which sounds (if any) are incorrect? ____

How many words can your child say? (list if fewer than fifteen) ____________________

How long are your child's sentences? ____

Does your child have any difficulty understanding you? (describe) _________________

Does your child have difficulty following directions? (describe) ____________________

Any speech or language problems in the immediate or extended family (explain)?

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Social Development

Names and ages of siblings: ____

How does your child handle frustration: _______ conflict: ______ separation:______

What motivates your child most? ____

School History

Has your child attended day care? Nursery School? ______________________________

What is the name of your child’s school/teacher? ________________________________

How does your child's teacher describe his/her performance? ______________________

Has the teacher expressed any concern? If so, what? _____________________________

**What do you hope to have happen as a result of this therapy? ____________________

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