CASE HISTORY

Child's Name: _____ Date of Birth: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
Mother: _____ Father: _____
Email: _____

Describe the nature of your concerns: _____
_____
When did you first become concerned? _____

Has your child ever received any of the following evaluations/treatments? If so, when and where?
Physical Therapy _____
Occupational Therapy _____
Speech Therapy _____
Hearing Evaluation _____
Vision Evaluation _____
Psychological _____

DEVELOPMENTAL HISTORY

Was this a normal pregnancy? Y N If no, what were the complications? _____
_____
Length of pregnancy: _____ Birth Weight: _____
Did your child feed well after birth? Y N If no, explain: _____
_____

At what age did your child:

Roll over _____
Sit alone _____
Crawl _____
Begin babbling _____
Say first word _____
Speak in sentences _____
Stand _____
Walk alone _____
Spoon feed self _____
Respond to name _____
Put 2-3 words together _____

What language(s) do you speak in your home? _____
What is your child's primary language? _____

How does your child make his/her wants/needs known?

Eye gaze _____ Vocalizations _____ Pointing _____
Words _____ Sentences _____ Crying _____
Other: _____

MEDICAL HISTORY

Pediatrician (or Group Name): _____

Pediatrician's Phone/Address: _____

Please check any of the following your child has had:

Adnoidectomy	_____	Tonsillectomy	_____	Allergies	_____
Heart Problems	_____	Bronchitis	_____	Pneumonia	_____
Seizures	_____	Ear Infections	_____	Meningitis	_____
Encephalitis	_____	Headaches	_____	Feeding Problems	_____
Drooling	_____	Reflux	_____	Other	_____

Please explain: _____

_____

Have any medical/genetic tests been completed? Y N If yes, please list name, date and results:

_____

_____

Has your child ever been hospitalized? Y N If yes, please list dates and reasons:

_____

_____

_____

Current medications: _____

Allergies: _____

SCHOOL HISTORY

Does your child attend:

Day care	_____	Preschool	_____	Elementary	_____	Home	____
Middle School	_____	High School	_____	Grade Level	_____		

Name of School: _____

Have any learning problems been identified? _____

_____

FEEDING HISTORY

What are your child's favorite foods? _____

What are some foods your child won't eat? _____

How often does your child eat? _____ How long does it take: _____

Circle how your child receives/eats their food:

bottle	fingers	fork/spoon
straw	sippy cup	cup edge

Does your child demonstrate any of the following behaviors during or after mealtime?

gagging coughing stuffing mouth turns head away

refuses certain textures of food spits out foods/liquids

difficulty breathing when eating excessive swallowing &/or throat clearing

Please list on the back of this page what you want your child to achieve in therapy as well as their interests and strengths. Please include siblings' names and ages as well as any pets.