CHILDREN'S THERAPY SPECIALISTS

Children's Therapy Specialists
tschrader@childrenstherapymn.com
Phone: (952) 955-3323 | Fax: (952) 955-3324
200 Lewis Ave, Ste. 230, Watertown, MN 55388

CASE HISTORY FORM

GENERAL INFORMATION:

Child's Name:	
Date of Birth:	
Age:	
Person Providing the Information:	
Today's Date:	
Sex:	
Home Address:	
Home Telephone Number:	
Mother's Name:	
Mother's Cell Phone Number:	
Mother's E-mail Address:	
Father's Name:	
Father's Cell Phone Number:	
E-mail Address:	
PRIMARY CLINIC:	
PRIMARY PHYSICIAN:	
PHONE NUMBER:	
ADDRESS:	
Please describe the reason for the evaluation/ main concerns:	

FAMILY HISTORY:

Father's Name:			
Age:			
Occupation:			
Work Phone Number:			
Mother's Name:			
Age:			
Occupation:			
Work Phone Number:			
Is your child adopted? If so, at what age, and from what country:	**YES**	**NO**	
Are parents:	**YES**	**NO**	**Married**
	YES	**NO**	**Living Together**
	YES	**NO**	**Separated**
	YES	**NO**	**Divorced**
Names and ages of siblings:			

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FAMILY HISTORY OF THE FOLLOWING:

	YES	NO	COMMENTS
Learning Disabilities			
Speech/Language Disabilities			
Motor Delays			
Sensory Integration Disorder			
Attention/Hyperactivity Concerns			
Short Term/Working Memory Deficits			
Long Term Memory Deficits			
Visual Processing Deficits			

PREGNANCY, BIRTH HISTORY, INFANCY:

	YES	NO	COMMENTS
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy?			
2. Was this pregnancy full term? If not please give gestational age and weight at time of delivery.			
3. Were there any drugs or medications taken during this pregnancy? Is so please specify.			
4. Were there any difficulties with labor or delivery?			
5. Please list birth weight and length.			
6. Was the delivery vaginal, breech, or caesarian? Were forceps/suction used?			
7. Did your child bottle or breast feed? How long?	Breast	Bottle	
8. Did your child have difficulty sucking?			
9. Did your child have normal feeding, weight gain, sleeping patterns?			

MEDICAL HISTORY:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:	Yes	No	COMMENTS
a. Meningitis			
b. Chicken Pox			
c. Seizures			
d. Frequent Ear Infections Does your child have PE tubes? If so, when?			
e. Excessive vomiting or reflux. Does/did your child have irritability/fussiness following feedings?			
f. Current or past history of feeding or swallowing difficulties.			
g. Cleft Lip/Cleft Palate Please give detailed history.			
h. Vision Problems			
i. Respiratory Illness or asthma			
2. Does your child use any adaptive equipment?			
3. Please list current and past medications.			
4. Has your child ever been hospitalized? If so, when and what for?			
5. Does your child have any allergies? If so, please list.			
6. What were the results of your child's most recent audiological evaluation and when was it completed?			

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GROWTH and DEVELOPMENT (Please complete this section if your child is 5 years of age or younger). Please list ages for the following developmental milestones:

	AGE	COMMENTS
a. Roll over from stomach to back		
b. Roll over from back to stomach		
c. Sit independently		
d. Crawl		
e. Walk independently		
f. Babble		
g. First Word		
h. Use two word combinations		
i. Transition to a cup (discontinued breast or bottle)		
j. Use a spoon		
k. Dress independently		
l. Toilet trained		

DESCRIBE YOUR CHILD:

	YES	NO	COMMENTS
a. Mostly quiet			
b. Overactive			
c. Tires easily			
d. Talks constantly			
e. Impulsive			
f. Restless			
g. Stubborn			
h. Resistant to changes			
i. Over reacts			
j. Usually happy			
k. Frequent temper tantrums			
l. Clumsy			
m. Difficulty separating from caregiver			
n. Anxious			
o. Poor attention span			
p. Frustrated easily			
q. Unusual fears			
r. Rocks self frequently			
s. Avoids touch			
t. Craves touch, seeks it out			
u. Shy			
v. Exhibits difficulty learning new tasks			

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COMMUNICATION HISTORY (Complete this section if your child is 5 years of age or younger):

1. How does your child communicate? (e.g. words, phrases, sentences, sign language, gestures, augmentative communication device)			
2. Estimate how many words are in your child's vocabulary?	**Under 25 words:**	**25 to 75 words:**	**Over 75 words:**
a. Expressive vocabulary (use of words)			
b. Receptive Vocabulary (understanding of language)			

3. Does your child:	**Yes**	**No**	**COMMENTS**
a. Point or gesture to communicate needs?			
b. Understand and follow simple directives?			
c. Identify body parts			
d. Recognize pictures of common objects			
e. Turn his/her head when name is called			
f. Communicate intent			
g. Use a pacifier or suck his/her thumb?			
4. Is a language other than English spoken at home? If so, which one.			

SOCIAL/EMOTIONAL DEVELOPMENT:

	Yes	**No**	**COMMENTS**
1. Is your child managed easily at home?			
2. Does your child empathize with others feelings? (happy, sad, angry…)			
3. Does your child understand praise and reward?			
4. Does your child recognize danger?			
5. Does your child show concern when separated from adults?			
6. Is your child affectionate toward familiar adults?			
7. Does your child have friends?			
8. Does your child have regular opportunities to play with his/her peers?			

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EDUCATIONAL BACKGROUND:

1. Does your child attend school?	**YES**	**NO**	**Where?**
2. What grade is he/she currently in?			
3. Does your child receive special education services? If so, please list frequency, length of sessions, and individual or group.	**YES**	**NO**	**Please provide a copy of your child's current IFSP or IEP.**
4. May we communicate with educational staff? If so, please list names of professionals.	**YES**	**NO**	
5. Where has your child previously received speech therapy related to his/her current problems?			
6. Is there anything else you want us to know about your child/family?			
7. What are the goals for your child seeking therapy?			
Please describe any therapy precautions we should be aware of:			
Does your child have any food allergies? Any dietary restrictions?			
The family requests the results of this evaluation should be sent to:			

***Please complete consent/release of information form.**

THANK-YOU very much for completing this form! We appreciate and value your time. The information obtained from this form will help your child's speech-language pathologist determine the most appropriate assessment materials to be used during the evaluation.