

WHITEFISH THERAPY & SPORT CENTER

CHILD CASE HISTORY FORM: SPEECH, PHYSICAL, OCCUPATIONAL

Child's Name: _____ Date of birth: _____

Person filling out this form: _____

Relationship to child: Mother Father Other: _____

Would you like to receive a text or email reminder of appointments?

Yes

No

If yes, please provide cell phone number with cell phone provider or email address:

Child lives with (check all that apply):

Parents

Foster parent(s)

Split time with parents

Grandparent(s)

Single parent

Other _____

Please list siblings living in child's home:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

If English is not your primary language, please list other language(s): _____

Please indicate your present concerns:

PRENATAL/BIRTH HISTORY

Mother's illnesses, accidents, or infections during pregnancy:

Length of Pregnancy _____ Length of Labor _____

Time Spent in NICU (Neonatal Intensive Care Unit) _____

Any complications at delivery?

Did the child experience any of the following conditions immediately following birth?

- | | | |
|---|--|--|
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other:
_____ |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Infections | |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Feeding Problems | |
| <input type="checkbox"/> Oxygen Needed | <input type="checkbox"/> Sucking/Swallowing Problems | |

MEDICAL HISTORY: please check all that apply. Please provide the dates where applicable

- | | | |
|---|--|--|
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Other Injuries | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Illnesses | <input type="checkbox"/> Wears a Hearing Aid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Operations | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Diagnosed with ADHD/ADD | <input type="checkbox"/> Other Diagnoses:
_____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating or swallowing problems | _____ |
| <input type="checkbox"/> Head Injuries | | |

Please explain the items checked:

Medications: Please list child's current medications or attach list to be scanned, including: over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:

	Name of Medication	Dosage	Frequency	Route of Administration (e.g., oral, IV, etc)
1				
2				
3				
4				
5				

MOTOR AND SOCIAL DEVELOPMENT

At what age did the following first occur?

Rolling over: _____ Sitting up: _____ Eating solids: _____

Standing: _____ Taking steps: _____ First words: _____

Please check if your child is able to do the following:

- Use utensils
- Drink from an open cup
- Tie shoes
- Fasten buttons
- Dress him/herself

Does your child experience difficulty with bathing or grooming skills? If so, which ones?

Do you have concerns regarding your child's behavior?

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SPEECH-LANGUAGE HISTORY

Describe the child’s communication at the present time. (Please check all that apply).

- Grunts and points
- Screams
- Gestures
- Takes you to object
- Copies what you do
- Copies what you say
- Follows directions
- Single words
- Two-word phrases
- Longer phrases/sentences
- Unclear speech
- Stuttering
- Too soft
- Too loud
- Hoarse

EDUCATIONAL HISTORY

School/Daycare: _____

Grade/Teacher: _____

Is your child currently receiving therapy (school, home, etc)? Yes No

If so, what type and what days? _____

Has your child received therapy in the past? Yes No

If so, what type and for how long? _____

What are your goals for therapy?

What are some of your child’s favorite toys and/or characters?

Please provide other information you believe to be helpful in the development of your child’s care here with us at Whitefish Therapy and Sport Center. Thank you.
