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?

- ☐ Breathing Difficulties
- ☐ Jaundice
- ☐ Bleeding
- ☐ Oxygen Needed
- ☐ Seizures
- ☐ Infections
- ☐ Feeding Problems
- ☐ Sucking/Swallowing Problems
- ☐ Other: _____

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

- ☐ High Fever
- ☐ Ear Infections
- ☐ Seizures
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Allergies
- ☐ Head Injuries
- ☐ Other Injuries
- ☐ Hospitalizations
- ☐ Illnesses
- ☐ Operations
- ☐ Diagnosed with ADHD/ADD
- ☐ Eating or swallowing problems
- ☐ Wears Glasses
- ☐ Hearing Problems
- ☐ Wears a Hearing Aid
- ☐ Behavioral Problems
- ☐ Other Diagnoses: _____ _____

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?

_____

_____

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.

_____

_____

_____