Children's Hospital of The King's Daughters Health System

Physical, Occupational and Speech Therapy Case History Form

Dear Parent/Caregiver:

Please complete the following Case History Form. Please give the form to the evaluating therapist upon arrival for your initial OT/PT/ST evaluation. Thank you in advance for your time.

Date: _____
Name of person completing Case History Form: _____
Relationship to child: _____
Language(s) spoken in the home: _____

Please list or briefly describe the concern and goals you have regarding your child's development:

_____
_____

IDENTIFYING INFORMATION/ FAMILY HISTORY:
Child's Name: _____ Date of Birth: _____ Age: _____
Address: _____
City/ State: _____ Zip: _____
Phone Number: _____ Alternate Phone Number: _____

Mother/ Guardian's Name: _____ Age: _____
Address: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____

Father/ Guardian's Name: _____ Age: _____
Address: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____

Please list brothers/sisters in the home:
_____

Please briefly describe any family member's significant developmental problems:
_____

Educational Information:
Your child's school: _____Phone:_____
Grade: _____ Teacher's Name: _____
Does your child receive special education services, PT/OT/ST? If so, please include length of time per day: _____

Please list any concerns that were voiced by the staff regarding your child's performance, general development or behavior:
_____

MEDICAL/DEVELOPMENTAL INFORMATION:
Referring Physician: _____Phone_____
Primary Care Physician: _____Phone_____

Please describe your child's birth history. List any complication during pregnancy, birth, or infancy:
_____
_____

Birth Weight: _____ pounds _____ ounces **APGAR** scores: _____
Please list any childhood illnesses and/or medical conditions: _____
_____
_____
Please list any childhood illnesses or medical conditions (past and present):
_____
_____

Please list any current medications and reason for medication: _____
_____
_____

Please list any allergies (Environmental, food, diet restrictions): _____
_____

Please list any surgical procedures and/or hospitalizations (include dates): _____

Does your child suffer from chronic ear infections? Please describe frequency and treatment: _____
_____

Has your child had a formal eye examination? Please describe: _____
_____

Has your child had a hearing test? Has your child had tubes in his/her ears, hearing aids, or cochlear implant? Please describe: _____

Please record the approximate age at which your child was first observed doing the following skills:

Speech Skills	Age	Motor Skills	Age
Babbling		Sitting unassisted	
Imitation of sounds		Crawling	
First word		Walking	
2-word utterance		Drinking from cup	
Phrases/ Sentences		Spoon feeding self	
Reaching		Chewing solid food	

UNDERSTANDING LANGUAGE/ COMMUNICATING:
Does your child react or respond to sounds? When you talk to your child, how much does he/she understand (a few words, phrases, directions)? Please describe:
_____
_____

How does your child usually let you know what he/she wants (cries, points, makes sounds, few words, stretch sounds/long sentences, facial tension, stutter)? Please describe: _____
_____

SOCIAL BEHAVIOR:
Please describe any social concerns (short attention span, interaction with children and adults, overly active, aggressive behaviors): _____
_____
_____

FEEDING/ SWALLOWING:
Please describe any feeding and/or swallowing concerns (difficulty biting/chewing, accepting new foods/textures): _____
_____

CHILD OBSERVATIONS:
Please describe how your child ascends/descends the stairs: _____
_____

Has your child established a hand preference? Right ___ Left___

Please describe how much help, if any, your child requires with self-care skills (dressing, bathing, feeding, etc. _____

Please describe your child's balance skills and motor coordination:

_____
_____
_____

Please describe any sensory issues/concerns (sensitivity to touch, smell, and sound, gets dizzy and/or tires easily, avoids/craves messy activities):

_____

Please list any activities that your child particularly enjoys or things that may be useful as rewards:

_____
_____

ADDITIONAL COMMENTS: Please write any further comments that you feel may assist the therapist:

_____
_____