ENVISION HOPE
pediatric therapy

Case History

General Information

Child's Name:_____ Date of Birth:_____

Address:_____ Phone: _____

City/State/Zip:_____

Mother's Name:_____ Cell Phone:_____

Address:_____

Email Address:_____

Employer:_____

Father's Name:_____ Cell Phone:_____

Address:_____

Email Address:_____

Employer:_____

Siblings:

Name	Age	Special needs

Referred by:_____

Primary Care Physician:_____ Phone: _____

In case of emergency, contact:

Name:_____ Phone:_____

What are your primary concerns/reasons for today's visit?

Previous Treatment and/or Therapies

Type of Therapy/Treatment	Dates	Focus of Treatment

Where you happy with your child's therapist and progress? Y/N

Please explain:

Has your child been seen by another specialist (Neurologist, psychologist…)? ☐ No ☐ Yes

What were the findings? Does your child have any diagnoses?

If your child has a diagnosis:

Date of Diagnosis: _____

Do you have any questions/concerns about accuracy of diagnosis? Y/N

If yes, please explain:

Allergies:

Allergies	Yes/No	Please list
Medications		
Food		
Environmental respiratory agents		

Family History (check all that apply)

☐ Diabetes	☐ Alzheimer's	☐ Tay-Sachs Disease	☐ Speech/Lang Delay
☐ Allergies:	☐ Cerebral Palsy	☐ Learning Difficulties	☐ Autism
☐ Seizures/Epilepsy	☐ Hemophilia	☐ Kidney problems	☐ Hearing Impairment
☐ Cancer	☐ Huntington's Chorea	☐ Multiple Sclerosis	☐ GI problems
☐ Heart Disease	☐ Muscular Dystrophy	☐ Alcohol/Drug Abuse	☐ Tourette's syndrome
☐ Stroke	☐ Asthma	☐ Behavior disorder	☐ Tics
☐ Tuberculosis	☐ Parkinson's Disease	☐ Emotional Disturbance	☐ Cleft palate
☐ Low muscle tone	☐ Sickle-cell anemia	☐ Mental Illness	☐ Other:

Prenatal and Birth History

Describe mother's general health during pregnancy: _____

_____

Describe any unusual conditions which existed during this pregnancy (illness, medications, Rh incompatibility, hemorrhage, physical illness, accident, emotional upset, etc.): _____

_____

Length of pregnancy:_____weeks
Birth Weight:_____pounds,_____ounces

Describe any complications during delivery (i.e., breech, Caesarian, emergency C-section:_____

_____

Describe the health of your child during the first days of life (Apgar scores, abnormalities, breathing problems, jaundice, feeding difficulties, etc.): _____

_____

Describe anything else you might feel is important about your child's birth or hospital stay: _____

_____

What is your child's first language? _____

What language(s) are used at home? _____

Child's Medical History (check all that apply)

☐ Allergies	☐ Cerebral Palsy	☐ Frequent diarrhea	☐ GI problems/Reflux

☐ Seizures
☐ Frequent vomiting
☐ Frequent colds
☐ Meningitis
☐ Sinusitis
☐ Low Muscle Tone
☐ Cleft Palate
☐ Feeding Problems (describe):

☐ Croup
☐ High fever
☐ Frequent Ear Infections
☐ Asthma
☐ Rashes
☐ Clumsiness
☐ Swallowing problems

☐ Kidney Problems
☐ Tonsil/Adenoidectomy
☐ Bronchitis
☐ Heart trouble
☐ Failure to thrive
☐ Broken bones
☐ Trauma

☐ Strep Throat
☐ Head Injury
☐ Tics
☐ Psychological Issues
☐ Encephalitis
☐ Other:_____

Childhood Illnesses:_____

_____

Major accidents/Injuries/hospitalizations:_____

_____

Medications (prescribed or over the counter)
Please list and provide dosage and frequency:_____

_____

_____

Vision Assessment (date/results):
_____

Hearing Problem Suspected: ☐ Yes ☐No
PE tubes: ☐ Yes ☐ No Number of times placed:_____
Are tubes still present: ☐ Yes ☐No Which ear? _____
Hearing Aids: ☐ Yes ☐No
Cochlear Implants: ☐ Yes ☐No
Hearing Assessment(date/results):_____

Developmental History
Fine and Gross Motor Milestones:

Skill	Age
Hold head without support	_____
Sit without support	_____
Crawl	_____
Stand alone	_____
Walk alone	_____
Gain bladder control	_____
Gain bowel control	_____

Skill	Age
Finger-feed	_____
Use spoon to eat	_____
Drink from a straw	_____
Drink from an open cup	_____
Accept solid food	_____

Feeding Milestone:

Behaviors:

☐ Poor attention/difficulty focusing
☐ Inappropriate play behavior
☐ Poor joint attention
☐ Difficulty calming self
☐ Difficulty with transitions/change
☐ Difficulty showing affection/emotion
☐ Dependent upon routines
☐ Poor eye contact
☐ Difficulty with peer interactions
☐ Stereotyped mannerisms
☐ Destructive/aggressive
☐ Sleeping difficulties
☐ Tantrums
☐ Defiant
☐ Difficulty following directions
☐ Other:_____
☐ Impulsive
☐ Restrictive interests
☐ Unusual eating habits
☐ Excessive fears
☐ Overly active
☐ Nervous
☐ Self-abusive behavior

Please check the amount of assistance needed for your child to complete the following:

Self-Care	**Independent**	**Needs more than 50% help**	**Total assistance – Dependent**
Takes off pants			
Puts on pants			
Takes off shirt			
Puts on shirt			
Buttons			
Zippers			
Snaps			
Puts on shoes			
Takes off shoes			
Ties shoes			
Puts on socks			
Takes off socks			
Wipes bottom (toileting)			
Washes body in bathtub			
Brushes Teeth			
Scoops with spoon			
Spears with fork			
Drinks from open cup			

Describe your child at present:

	Yes	**No**	**Sometimes**
Overly active			
Tires easily			
Talks constantly			
Too impulsive			
Restless			
Stubborn			
Resistance to change			
Fights frequently			
Usually happy			
Exhibits temper tantrums			
Nervous ticks/habits			
Wets bed			
Frustrated easily			
Unusual fear			
Difficultly falling asleep			
Difficultly staying asleep			
Sluggish in mornings			
Rocks self frequently			

List some of your child's preferred toys, activities or interest: _____

_____

Educational Setting

☐ Daycare: _____

☐ Mother's Day Out: _____

☐ Preschool: _____

☐ School: _____Grade: _____

☐ Special Settings:

☐ IEP	☐ 504	☐ Dyslexia Program
☐ Resource	☐ Life Skills	☐ Functional Academics

☐ Adaptive Equipment: _____

☐ Therapies received at school and frequency: ☐ ST _____ ☐ OT _____ ☐ PT _____

Do you have any academic/educational concerns? Y/N

Please explain if yes:

_____

_____

_____

_____

Has your child's teachers expressed any academic/educational concerns? Y/N

Please explain if yes:

_____

_____

_____

_____

Do you have any social concerns? Y/N

Please explain if yes:

_____

_____

_____

_____

Has your child's teachers expressed any social concerns? Y/N

Please explain if yes:

_____

_____

_____

_____

Person completing this form**:* _____Relationship:*** _____

Signature: _____***Date:*** _____