Paloma Behavioral

Case History Packet

Occupational Therapy Services
Speech and Language Therapy Services

410 N. Wickham Rd.
Melbourne Florida, 32935
Phone: (321) 622-6884

Directions: Please complete the packet with accurate information in its entirety. If you are unsure of an answer, mark what you think is true for your child in most situations. If the item is not pertinent to your child, write N/A. If the child is fostered and accurate birth history is unknown, please write “unknown history” and fill only the parts you do know. Feel free to write additional information on the sides, bottom, or back of the paper. The information provided in this report is pertinent to the evaluation process and reports that will be part of the comprehensive evaluation process.

Note: The case history packet only needs to be completed one time. Occupational, speech, and language therapy will share the same packet.

Paloma Behavioral Case History Form

*** Occupational Therapy Services * Speech and Language Therapy Services ***

Client's Information:

Client's Name:	
Date of Birth:	
Home Address:	
Home Phone:	
Languages Spoken:	
School/Grade:	

Parent 1:

Name:	
Relationship with Client:	
Cell Phone	
Occupation	
Work Phone	
Email	

Parent 2:

Name:	
Relationship with Client:	
Cell Phone	
Occupation	
Work Phone	
Email	

Referral Information:

Referred By:	
Doctor's Name:	
Doctor's Phone:	

Child lives with (check one):

_____Birth Parents _____Foster Parents

_____Adoptive Parents _____One Parent

_____Parent & Stepparent _____Other: _____

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Family History:

Siblings:	Age:

Is there a family history of: (circle one)

Speech/Language Difficulties	Yes / No
Hearing Impairment/Deafness	Yes / No
Learning Difficulties	Yes / No
Developmental Difficulties	Yes / No
Attentional Difficulties	Yes / No
Mental Health Conditions	Yes / No

If you responded “yes” to any of the above, please describe:

_____

_____

_____

Statement of the Problem:

What are your top 3 areas of concern:

1_____

2_____

3_____

What are the top 3 interests and strengths you see in the child:

1_____

2_____

3_____

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Diagnostic History:

[ ] Check if no formal diagnosis

Formal Diagnosis:	Date of Diagnosis:	By Whom?

Pregnancy/Birth History:

	Check, Circle, or List
Prenatal care provided	Yes / No
Pregnancy was	Normal / Complicated
If complicated, please elaborate:	[ ] Spotting [ ] High blood pressure [ ] Diabetes [ ] Smoking [ ] Preexisting condition [ ] Fever [ ] RH incompatibility [ ] Medications [ ] Alcohol [ ] Drug [ ] Other _____
Pregnancy Term	[ ] Full at _____ weeks [ ] Premature at _____ weeks
Delivery	Vaginal / Cesarean
Presentation	Breech / Head down

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Labor	Induced / Natural
Length of Labor	
Birth weight	
Weight Leaving Hospital	
Special Consideration	[ ] Cord around neck [ ] Meconium Birth [ ] Jaundiced [ ] Twin (first / second) [ ] Incubation time [ ] Medication _____
Length of Hospital Stay	
Other complications before/during/slight after birth:	
Feeding Method	Breast fed / Bottle fed
Difficulty with Nursing?	Yes / No

Medical Information:

Allergies:	[ ] None known [ ] Seasonal: _____ [ ] Food: _____ [ ] Medication:_____
Special Diets:	[ ] No special diets [ ] Special diet _____ [ ] Avoids certain food dyes/types of food for preferential reasons: _____ _____

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Medical Devices	[ ] None [ ] Orthotics _____ [ ] Wheelchair or medical stroller _____ [ ] Adaptive seating _____ [ ] Sensory chews _____ [ ] Communication device (list type and program) _____ _____ [ ] Adaptive Equipment (list) _____ [ ] Weighted tools (list) _____ [ ] Writing tools (list) _____ [ ] Feeding tools (list) _____ [ ] Glasses/corrective lenses [ ] Other (list) _____

Hospitalizations or Surgeries:

[ ] Check if no hospitalizations or surgeries.

Date	Reason	Location

Has your child had any of the following? List approximate dates of when?

	Circle one	Date of Occurrence and Additional Details
Adenoidectomy	Yes / No	
Tonsillectomy	Yes / No	
Tonsilitis	Yes / No	
High Fever	Yes / No	
Head Injury	Yes / No	
Breathing Difficulties	Yes / No	

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Sleeping Difficulties	Yes / No	
Chicken Pox	Yes / No	
Thumb/Finger Sucking	Yes / No	
Frequent Colds	Yes / No	
Vision Problems	Yes / No	

Specialists Seen

Specialist:	**Circle One**	**If Yes, Elaborate**
Neurologist	Yes / No	
ENT	Yes / No	
Orthopedist	Yes / No	
GI	Yes / No	
Cardiologist	Yes / No	
Other: _____	Yes / No	

Current Medications:

[ ] Check if no medications

Medication	**Dosage**	**Frequency**

Vision: (check all that apply)

[ ] Within normal and functional limits (as determined by formal screening)

[ ] Perceived to be within normal and functional limits

[ ] Has glasses for _____

[ ] Has corrective lenses for _____

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[ ] Has an ocular motor or visual acuity difficulty _____

[ ] Low vision

[ ] Has had surgery _____

Dental: (note if teeth are present, any abnormalities or overbites)

[ ] Teeth present

[ ] overbite

[ ] underbite

[ ] braces

[ ] Within normal and functional limits (as determined by formal screening)

[ ] Perceived to be within normal and functional limits

[ ] Currently has braces or device: _____

[ ] Has had teeth removed: _____

[ ] Has had dental surgery: _____

Hearing:

	Circle One
Three or more ear infections between birth and 12 months of age	Yes / No
Frequent ear infections	Yes / No
At least one ear infection which lasted more than three months	Yes / No
An audiologist has determined that his/her hearing is within normal limits. Date of screening: _____	Yes / No
I suspect a hearing problem.	Yes / No
Preference of one ear over the other. If yes, which ear? (Circle) **Right / Left**	Yes / No
Tubes put in the ears. If yes, when?	Yes / No
My child wears hearing aids. If yes, what type and for how long? _____	Yes / No

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Oral Motor & Feeding History:

	Circle One
Feeding or eating difficulties	Yes / No
Able to self-feed	Yes / No
Use of a spoon	Yes / No
Use of a fork	Yes / No
Use of a knife	Yes / No
Use of an open cup	Yes / No
Use of a straw	Yes / No
Drooling	Yes / No
Mouthing of non-food objects	Yes / No
Sensitive to food textures	Yes / No
Sensitive to food temperatures	Yes / No
Sensitive to smells of foods	Yes / No
Coughing during or after eating	Yes / No
Watering eyes during or after eating	Yes / No
Face turns red during or after eating	Yes / No
Wet voice or gurgling sounds during or after eating	Yes / No
Picky eater	Yes / No
Messy eater	Yes / No
Choking while eating	Yes / No
Able to bite off foods	Yes / No
Overstuffs mouth	Yes / No
Chewing difficulties	Yes / No
Swallowing difficulties	Yes / No

List of Preferred Foods:

_____

_____

_____

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Speech, Language and Hearing Development:

	Circle or List
Babbling or cooing sounds during the first 6 months?	Yes / No
Age of first word	
First words (list)	
Did your child continue adding words once he/she started talking?	Yes / No
Age when they began using 2 and 3 words sentences?	
Did speech learning ever seem to stop for a period of time? If yes, explain.	
Does your child talk a lot?	Yes / Occasionally / Never
Use of gestures?	Yes / No
Use of gestures in combination with verbal speech?	Yes / No
Prefers gesturing over talking?	Yes / No
Child frequently uses (check all that apply)	[ ] Sounds [ ] Word approximations [ ] Single words [ ] 2 word sentences [ ] 3 word sentences [ ] Phrase speech [ ] more than 3 word sentences (fluent speech)
The Child's speech is (check all that apply)	[ ] Echoed/copied immediately [ ] Delayed echo/repeating [ ] Spontaneous [ ] Talks about own emotions [ ] Well directed to others [ ] Considerate of another person's emotions, thoughts, or experiences
Makes sounds incorrectly? If yes, which ones?	Yes / No
Does your child hesitate, "get stuck", repeat, or stutter on sounds or words?	Yes / No
Recent changes in speech	[ ] No [ ] Yes _____ _____
Can tell a simple story?	Yes / No

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How well do parents/caregivers understand the child?	[ ] Always [ ] Most of the time [ ] Some of the time [ ] Rarely
How well do siblings understand the child?	[ ] Always [ ] Most of the time [ ] Some of the time [ ] Rarely
How well do teacher(s) understand the child?	[ ] Always [ ] Most of the time [ ] Some of the time [ ] Rarely
How well do friends understand the child?	[ ] Always [ ] Most of the time [ ] Some of the time [ ] Rarely
How well do strangers understand the child?	[ ] Always [ ] Most of the time [ ] Some of the time [ ] Rarely
Understands what you say to him or her? If no, explain	Yes / No
Consistently answers to their name	Yes / No
Makes appropriate eye contact with adults	Yes / No
Makes appropriate eye contact with peers	Yes / No
Identification of simple objects	Yes / No
Follows simple commands	Yes / No
Trouble remembering what you have told them	Yes / No
Enjoys looking at books	Yes / No
Enjoys being read to	Yes / No

Sensory and Motor Development:

If unknown or not yet applicable, put N/A or not yet.

Motor Milestone	Age at which it was Met	Additional Comments
Crawled		
Sat unsupported		
Stood		
Walked		
Self-fed		

Dresses self		
Bladder trained		
Bowel trained		
Stays dry all night		

Motor Skill	**Select One (if unknown, select "no')**
Walks (well coordinated)	[ ] Yes [ ] No [ ] Sometimes
Runs	[ ] Yes [ ] No [ ] Sometimes
Skips	[ ] Yes [ ] No [ ] Sometimes
Tippy toe walk	[ ] Yes [ ] No [ ] Sometimes
Clumsy or fall easily	[ ] Yes [ ] No [ ] Sometimes
Appears floppy	[ ] Yes [ ] No [ ] Sometimes
Muscles and body feel tight	[ ] Yes [ ] No [ ] Sometimes
Able to transfer from sitting to standing and standing to sitting independently	[ ] Yes [ ] No [ ] Sometimes
Uses arms to help balance body	[ ] Yes [ ] No [ ] Sometimes
Can isolate the movement of fingers	[ ] Yes [ ] No [ ] Sometimes
Completes handwriting tasks	[ ] Yes [ ] No [ ] Sometimes
Uses scissors independently	[ ] Yes [ ] No [ ] Sometimes
Stacks blocks	[ ] Yes [ ] No [ ] Sometimes
Jumps up and down	[ ] Yes [ ] No [ ] Sometimes
Jumps forward	[ ] Yes [ ] No [ ] Sometimes
Throws and catches objects/balls	[ ] Yes [ ] No [ ] Sometimes
Opens and closes containers	[ ] Yes [ ] No [ ] Sometimes
Wipes self in the bathroom	[ ] Yes [ ] No [ ] Sometimes
Washes hands thoroughly	[ ] Yes [ ] No [ ] Sometimes
Brushes teeth well	[ ] Yes [ ] No [ ] Sometimes
Washes face	[ ] Yes [ ] No [ ] Sometimes
Brushes/combs hair	[ ] Yes [ ] No [ ] Sometimes
Hand Preference	Right / Left / Both / Neither

Awkward movements or grasp	[ ] Yes [ ] No [ ] Sometimes

Sensory Preferences	**Check One**
Being picked up or feet off the ground?	[ ] seeks [ ] neutral [ ] avoids
Swinging	[ ] seeks [ ] neutral [ ] avoids
Spinning	[ ] seeks [ ] neutral [ ] avoids
Movement	[ ] seeks [ ] neutral [ ] avoids
Wet/messy play	[ ] seeks [ ] neutral [ ] avoids
Light touch	[ ] seeks [ ] neutral [ ] avoids
Deep pressure (such as crashing their body or deep hugs)	[ ] seeks [ ] neutral [ ] avoids
Strong food flavors (salt, spices, etc.)	[ ] seeks [ ] neutral [ ] avoids
Sucks on hair/clothing/blankets/toys, etc.	[ ] seeks [ ] neutral [ ] avoids
Teeth brushing	[ ] seeks [ ] neutral [ ] avoids
Loud or unexpected sounds	[ ] seeks [ ] neutral [ ] avoids
Crowded places	[ ] seeks [ ] neutral [ ] avoids
Bright lights	[ ] seeks [ ] neutral [ ] avoids
Tags on clothing	[ ] seeks [ ] neutral [ ] avoids
Seams in clothing	[ ] seeks [ ] neutral [ ] avoids
Can self-regulate and calm in response to movement	[ ] Yes [ ] No [ ] Sometimes
Gets carsick	[ ] Yes [ ] No [ ] Sometimes

Play skills	
Child prefers to play:	[ ] alone [ ] with other children [ ] with older children [ ] with younger children [ ] with adults
Pretend and imaginative play	[ ] Yes [ ] No [ ] Sometimes
Reciprocal passing of a ball/cars/toys	[ ] Yes [ ] No [ ] Sometimes
Lines up toys	[ ] Yes [ ] No [ ] Sometimes

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Organizes toys by type	[ ] Yes [ ] No [ ] Sometimes
Frequently breaks toys	[ ] Yes [ ] No [ ] Sometimes
Cause and effect skills	[ ] Yes [ ] No [ ] Sometimes
Prefers quiet pursuits	[ ] Yes [ ] No [ ] Sometimes
Prefers active pursuits	[ ] Yes [ ] No [ ] Sometimes
Board games	[ ] Yes [ ] No [ ] Sometimes
Sport activities	[ ] Yes [ ] No [ ] Sometimes
Attends until a task reaches a natural conclusion	[ ] Yes [ ] No [ ] Sometimes

Educational History:

School Attended	Dates Attended	Additional Comments (optional)

History of Therapeutic Services:

If the services have been received, please include details on the clinic, provider, frequency/duration of treatment sessions, and any other relevant information.

Therapeutic Service	*Received Service*	*Location / Provider*	*Additional Details*
Early Intervention Services	[ ] No [ ] Yes, currently [ ] Yes, previously		
Occupational Therapy	[ ] No [ ] Yes, currently [ ] Yes, previously		
Speech and Language Therapy	[ ] No [ ] Yes, currently [ ] Yes, previously		
Physical Therapy	[ ] No [ ] Yes, currently [ ] Yes, previously		

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Music Therapy	[ ] No [ ] Yes, currently [ ] Yes, previously		
Hippotherapy	[ ] No [ ] Yes, currently [ ] Yes, previously		
Psychology	[ ] No [ ] Yes, currently [ ] Yes, previously		
Mental Health Counseling	[ ] No [ ] Yes, currently [ ] Yes, previously		
Psychiatry	[ ] No [ ] Yes, currently [ ] Yes, previously		
Feeding Therapy	[ ] No [ ] Yes, currently [ ] Yes, previously		
Other:	[ ] No [ ] Yes, currently [ ] Yes, previously		

Favorite Activities:

Type of Activity	Engagement in Activity (if yes, elaborate on what their favorites are)
Quiet pursuits	[ ] No [ ] Sometimes [ ] Yes _____
Active pursuits	[ ] No [ ] Sometimes [ ] Yes _____
Sensory Play	[ ] No [ ] Sometimes [ ] Yes _____
Characters	[ ] No [ ] Sometimes [ ] Yes _____
TV shows	[ ] No

	[ ] Sometimes [ ] Yes _____
Video games	[ ] No [ ] Sometimes [ ] Yes _____
Sports	[ ] No [ ] Sometimes [ ] Yes _____
Toys	[ ] No [ ] Sometimes [ ] Yes _____
Musical Instruments	[ ] No [ ] Sometimes [ ] Yes _____
Cooking	[ ] No [ ] Sometimes [ ] Yes _____
Chores	[ ] No [ ] Sometimes [ ] Yes _____
Other Leisure	[ ] No [ ] Sometimes [ ] Yes _____

This Packet has been completed by: _____

Relationship with client: _____

Date of completion: _____