Patient Case History

General Information

1.Parent's Name:_____
2.Patient's Address:_____
3.Patient's Name: (first)_____(middle)_____(Last)_____
4.Patient's Birthday:_____ 5. Patient's Gender_____
6. Caregiver's Phone: (____)_____ 7. Email address:_____
8. Who referred your to therapy? _____ 9. Pediatrician:_____
10. What concerns/expectations do you have for your child's visit?_____
_____

Family/Social Information

1.What is the primary language spoken by the patient?_____
2.What is the primary language spoken in the child's home?_____
3.Who lives in the home where the child currently resides?_____
4.What is the marital status of the child's caregiver(s)? _____

Education

1.What type of education/daycare does your child receive?_____
2.What is your child's current school grade?_____
3. Child's school/daycare name?_____ 4. In what county?_____
5. Does your child have a current school IEP or 504 Plan? If so, which one and date implemented _____

Pregnancy and Birth History

1.What was the length of pregnancy?_____weeks 2. What was the birth method?_____
3.List any notable conditions **AT** birth:_____
4.What was the child's birth weight?_____lbs____oz.
5.List any notable conditions your child had **AFTER** birth:_____

Health and Medical Information

1. List any current medication your child takes, along with the reason(s) for taking them:_____
_____
2.List any food allergies along with corresponding reaction(s) your child has:_____
_____
3. List any medication allergies along with corresponding reactions(s) your child has:_____
4.List any environmental allergies along with corresponding reaction(s) your child has:_____
5. Does your child have difficulties with vision or hearing (date of testing):_____
_____
6. Please list any medical conditions that your child has:_____

7.List any surgeries/injuries/special tests your child has received along with the date of occurrence:_____

Development

1. Were your child's A) cognitive developmental milestones met (i.e. ability to learn things similar to peers)?____
B) communicative developmental milestones met (i.e. ability to speak and understand/express thoughts)?_____
c) motor developmental milestones met (i.e. ability to move and control body parts similar to their peers)?_____
2. List any therapies your child has received *in the past* and in what kind of setting (i.e. Babies Can't Wait, private, school based, etc)_____
3. List any therapies your child *is currently receiving* and where they are being conducted:_____
_____
4.Does your child receive play therapy, counseling and/ or ABA (if so, please list):_____

Precautions:

1. List any precautions your child has due to medical reasons:_____
_____

Assistive Devices/Equipment:

1. List any special equipment your child currently uses for mobility:_____
2. List any orthotic/prosthetic devices your child currently uses:_____
3. List any other special equipment your child currently uses:_____
4. List any communication aides your child currently uses:_____

Gross motor

1. What age did your child sit independently:_____ Crawl on all fours:_____Walk alone_____
2. Can your child: Skip ____ Hop____Jump____Run____Balance on one foot____Ride a tricycle or bicycle ____ catch a ball____kick a ball____throw a ball____
3.Compared to peers, your child's development appears: more coordinated_____more clumsy_____ acts differently_____ does not do things easily

Activities of Daily Living (ADL's)

1. Is your child able to dress independently? _____If not, what do they need help with? _____
2. Is your child able to independently fasten/unfasten: Buttons____ Zippers___Snaps____Shoelaces____
3. Is your child able to feed themselves independently using a: spoon____fork____open cup____straw____
4. Is your child toilet trained:_____ If so, what age were they trained:_____

Sensory Processing

Does your child appear to be unusually sensitive to or avoid any of the following (please list either sensitive or avoid): Having hair washed_____ Having face/body washed_____ Brushing teeth_____
Having nails trimmed_____ Tags on clothes or wearing long pants/long sleeve shirt_____
Loud noises_____ Being in loud, crowded environments_____
Being hugged or touched by others _____ Picky eater (eating only certain foods/textures)_____
Movement (swings, slides, going upside down, etc) _____

Does your child seek out (circle all that may apply): rocking, jumping, crashing, biting/mouthing toys, spinning, repetitive activities, climbing, head banging, hitting.

Does your child appear (circle all that may apply): high pain tolerance, clumsy, distracted by sounds, distracted by visual stimuli, easily frustrated, aggressive, always tired.

How long can your child attend to a difficult task or a non-preferred task:_____

Play skills/social/peer interaction:

Does your child have difficulty learning new skills or playing new games: yes/no Examples_____

Will your child interact with peers independently: _____

What games, playground equipment or activities does your child **dislike:** _____

What activities does your child enjoy (games, hobbies, toys, sports, etc.):_____

Speech/Language Development:

Is your child able to understand (circle all that may apply) simple questions, 2-step directions, 3- step directions

How does your child communicate: speaking_____ grunting_____ pointing_____ gestures/signs_____ pictures cards_____

Do you have any concerns regarding your child's speech, language or hearing skills:_____

_____ _____

Printed name of person completing the form | Relationship to patient

_____ _____

Signature of person completing the form | Date