



PEDIATRIC CASE HISTORY INTAKE FORM

Please answer the questions as fully and accurately as possible. The information that you provide on this form will help to create a better understanding of your child and the course of evaluation and treatment. If you are unsure of a particular answer, mark with a question mark (?). If a question is not relevant to your child, please write "N/A."

All material and information is strictly confidential.

Patient's Name: _____ **Address:** _____

Date of Birth: _____

Age: _____

GENERAL INFORMATION

Parent's Name:	Phone:
Occupation:	Email Address:
Parent's Name:	Phone:
Occupation:	Email Address:

What Languages Are Spoken in the Home?	What is the Child's Primary Language?

Referred By:	Phone:
Relationship:	Email Address:

Primary Doctor:	Phone:
Office Name:	

Dentist:	Phone:
Orthodontist:	Phone:

Additional Specialist:	Area:
Office Name:	Phone:

Additional Specialist:	Area:
Office Name:	Phone:

FAMILY HISTORY

Child Lives with ☐ Birth Parents ☐ One Parent ☐ Split Custody ☐ Adoptive Parents ☐ Foster Parents
☐ Other:

Sibling Name	Age



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FAMILY HISTORY (continued)

Have any close family members been diagnosed with the following:

Speech or Language Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Learning Disabilities (i.e. dyslexia)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing Impairment/Deafness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Autism Spectrum Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
ADD or ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO
Motor Planning Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sensory Processing Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO

Family member(s)

MEDICAL HISTORY

Length of Pregnancy	_____
Illnesses, accidents, medications, etc.,	_____
General Condition at Birth	_____
Please describe any complications	_____

Please check the corresponding box if your child has been diagnosed with the following (if applicable):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Cleft Palate/Lip	<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Headaches	<input type="checkbox"/> High Fever	<input type="checkbox"/> Other Allergies
<input type="checkbox"/> Seizures	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Concussion	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Swallowing Problem	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Reflux	<input type="checkbox"/> Motor Planning Disorder
<input type="checkbox"/> Nerve Damage	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Diet Restrictions	<input type="checkbox"/> Sensory Processing Disorder

If any of the above have been checked, please provide the date of diagnosis and name of physician:

Has your child had any surgeries, major accidents or hospitalizations? Have they ever been under general anesthesia?
Please Describe:

Is your child taking any medications? If yes, please list:

Has your child ever undergone genetic testing? If yes, please share the findings:

Has your child had a hearing test? If so, when?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
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Has your child had a vision test? If so, when?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
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DEVELOPMENTAL HISTORY

Provide the approximate age at which your child began to do the following activities:

Crawl:	Sit:	Walk:
Feed Self:	Dress Self:	Use Toilet:
Use Single Words:	Combine Words:	Use Sentences:

How does your child primarily communicate?

<input type="checkbox"/> Gestures	<input type="checkbox"/> Single Words	<input type="checkbox"/> Short Phrases	<input type="checkbox"/> Sentences	<input type="checkbox"/> Conversation
<input type="checkbox"/> Alternative and Augmentative Communication Device:				

Does your child use a pacifier, suck thumb, chew on clothing, chew on pens/pencils, or have an attachment to putting other objects in their mouth such as "chewlery"? If yes, how often and under what circumstances?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Does your child have any feeding or eating problems (e.g. very picky eater, any problems tolerating specific food textures, swallowing, drooling, chewing, ect.)? If yes, please describe:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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From what does your child primarily drink?

<input type="checkbox"/> Bottle	<input type="checkbox"/> Sippy Cup	<input type="checkbox"/> 360 Cup	<input type="checkbox"/> Cup with Straw	<input type="checkbox"/> Open Cup
<input type="checkbox"/> NPO	<input type="checkbox"/> Other			

Does your child have difficulty walking, running, or participating in any activities that require large muscle coordination?
Do you feel your child is excessively clumsy?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Does your child require assistance with daily activities dressing, showering, use bathroom, feeding, etc? If yes, please describe the level of assistance needed.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Please share any additional information/ comments regarding your child's development that you feel is important:

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EDUCATIONAL HISTORY

School:	School District:
Grade:	Teacher:

The child currently has:

☐ Individualized Education Plan (IEP) ☐ Service Plan ☐ 504 Plan ☐ N/A

Date of most recent meeting: _____



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EDUCATIONAL HISTORY (continued)

If they have an IEP or 504, what programs, services, or instruction do they receive? If not, do they receive special help or interventions in the classroom to help them achieve success? Please describe:

Has your child been diagnosed with any type of learning disability? If so, please describe:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Does the child receive in school therapy services? (OT, Speech, Language, PT, Vision, etc.) If yes, please describe:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

How does the child interact with others (shy, aggressive, uncooperative, etc.)?

Has the child ever received private academic support services (tutoring)? If yes, please describe:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Provider:		

Has the child ever received private occupational, speech, or physical therapy services? If yes, please describe:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Provider:		

SENSORY INFORMATION

Does your child have an adverse (negative) reaction to any of the following?

Loud Noises	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bright Lights	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Certain Food Textures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Having Teeth Brushed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Having Face Touched	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Having Hair Brushed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tags in Clothes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wearing Socks/Shoes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wearing Tight Clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Car Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Being Hugged	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using the Bathroom (home)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using Public Restrooms	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Animals (dogs, cats)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sharing toys or activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Playground swings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dirt, Paint, etc., on hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Large Crowds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Doctor's Office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dentist's Office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New Routines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Separating from a familiar adult	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Music playing on stereo, phone, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Someone Singing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When asked to "clean up"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adult given directives	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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SENSORY INFORMATION (continued)

Does your child have a normal response to pain? (e.g. high pain tolerance, easily injured) If no, please describe.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Is your child what you might call hyperactive (always moving, can't sit still)? Please describe.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Does your child have difficulty paying attention/keeping focus for more than 30 minutes? Please describe.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Does your child engage in any repetitive behaviors? (e.g. rocking in chair, picking nails, fixing hair, etc.) Please describe.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	

ADDITIONAL INFORMATION

What are some of your child's strengths and accomplishments?

What are your goals for evaluation and therapy?

Please provide any additional information that might be helpful in the evaluation or remediation of your child's speech, language, fine motor, and/or sensory concerns.

AFFIRMATION OF INFORMATION

_____ I affirm that this packet has been completed accurately and to the best of my ability.

_____ I understand that I will receive an electronic copy of this form via email for my records.

_____ I understand that it is my responsibility to update my child's therapist with any changes to this form.

SIGNATURE

Person Completing Form:

Relationship to Child:

Signature:

Date: