14391 Metropolis Ave. #101/102
Fort Myers, FL 33912
Phone: (239) 561-2778
Fax: (239) 561-8107

THERAPY CASE HISTORY

Date: _____

Who is filling out this questionnaire? _____ Relationship to child: _____

Who told you about our practice? _____ Referring Doctor: _____

Child's doctor: _____ Group: _____ Location: _____

Child's specialist(s): (please provide names, phone numbers, and groups)

_____

_____

_____

_____

IDENTIFYING INFORMATION

Child's name: _____

Nickname: _____ Social Security Number _____

Date of birth: _____ Child's age: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Cell Phone #: _____ Work Phone #: _____

Home phone #: _____ Alternate phone #s: _____

Email address: _____

FAMILY INFORMATION

Child lives with: (circle one)

Birth parents Adoptive parents Foster parents Parent & Step-parent One parent
Other _____

	Name	Age	Occupation
Parent/Guardian:	_____	_____	_____
Parent/Guardian:	_____	_____	_____
Other (spouse, guardian, etc.):	_____	_____	_____
	_____	_____	_____

If the address of either parent is different from that of the child, please indicate:

_____

Was your child adopted? If so, when? _____

Other children in the family:

Name	Sex	Age	School & Grade	Deficit related to ST/OT/PT

Child's daytime caregiver(s):

Family member(s) School Daycare Program Babysitter/Nanny

Is there a language other than English spoken in the home? (circle one) YES NO

If yes, which one? _____ Does your child speak the language? YES NO

MEDICAL HISTORY

Month/year of last physical exam: _____ Doctor _____

Is your child in (circle one) *good* *fair* *poor* health?

Please list:

Illnesses/Accidents/Hospitalizations (include age):

_____

_____

_____

Allergies:

_____

_____

_____

Surgeries (include age/date):

_____

_____

_____

Treatments/Medications and dosages:

_____

_____

_____

Does your child have any of the following? (if yes, describe)

Visual deficit _____

Seizures _____

Hearing defect _____

Walking device _____

Brace or splint _____

Glasses _____

Hearing aid/tubes _____

Wheelchair _____

Feeding tube or ostomy site _____

Physical or limb defect _____

Cleft palate or defect of lip, cheeks, jaw, tongue, dentures

_____

Emotional, behavioral, or sleeping problems

_____

Dates of other pertinent medical examinations (e.g. neurological, psychological, and ENT):

Date: _____ Doctor: _____ Results: _____

Date: _____ Doctor: _____ Results: _____

Date: _____ Doctor: _____ Results: _____

FAMILY HISTORY

Has anyone in the family been diagnosed with any of the following? (circle and indicate relationship to child):

Learning disability _____ ADD/ADHD _____

Dyslexia _____ Delayed motor skill development _____

Speech/language delay/disorder _____ Autistic spectrum disorder/PDD _____

Sensory processing disorder _____ Hypotonia _____

EDUCATIONAL HISTORY

Child attends: Pre-school School Home-School Daycare

Grade level (if applicable—circle): Pre-school Kindergarten 1 2 3 4 5 6 7 8 9 10 11 12

Child's best subjects in school: _____

Areas of concern about child's performance in school:

_____

Has your child repeated a grade? YES NO If yes, which one? _____

What is your impression of your child's social skills?

_____

_____

Does your child display any behavioral or attentional issues at school?

_____

_____

Does your child participate in extracurricular activities/hobbies? YES NO If yes, please list:_____

_____

DEVELOPMENTAL HISTORY

This is our (check applicable option) child: biological foster adopted

Pregnancy

Which pregnancy was this child? 1 2 3 4 5

During the pregnancy, was there (circle all that apply):

Blood incompatibility Toxemia

Diabetes Smoking

Early labor Illness

Bleeding Chemical or substance abuse

Anything considered unusual during the pregnancy?

_____

Delivery

Birth weight: _____

Was the child born prematurely? YES NO If yes, by how many weeks? _____

Circle applicable option: Delivery was normal Caesarean Breech Other _____

Describe any complications during delivery:

_____

Newborn

During the first month was your child (indicate for how long):

Jaundiced _____ On life-support _____

In isolette _____ Sedated _____

Fed by tube _____ Other _____

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Infancy

Circle applicable rating:

Weight gain	appropriate	area of concern
Feeding	appropriate	area of concern
Crying	appropriate	area of concern
Sleep	appropriate	area of concern
Activity level	appropriate	area of concern
Cuddliness	appropriate	area of concern

Were there any feeding difficulties during infancy? YES NO

If yes, describe: _____

Did the child have difficulty transitioning to different food textures? YES NO
If yes, describe: _____

Does your child have a limited diet due to "picky eating"? YES NO

If yes, describe: _____

Developmental milestones (indicate age and describe any problems observed):

Sat unsupported	
Crawled	
Walked alone	
Ran	
First ate solids pureed	
Held bottle	
Toilet trained for Bladder control	
Toilet trained for Bowel control	
Stayed dry through the night	
Rolled over	
Undressed self	
First ate finger foods	
Drank from a cup	
Dressed self without help	
Stood unsupported	

Circle all that apply:

Your child uses which method(s) of feeding? finger feeds uses a fork a spoon an open cup a straw

Is adult assistance needed with feedings? YES NO If yes, explain: _____

Has your ever choked on solid foods? YES NO Does your child cough on liquids? YES NO

Does your child drool? YES NO If yes, when? _____

Did/does child use a pacifier? YES NO If no longer using, age weaned from pacifier: _____

Does child continue to mouth objects? YES NO

Did/does child suck his/her thumb/fingers? YES NO If yes, until when? _____

Does child suck on his/her hair/clothing/blankets/etc.? YES NO If yes, what? _____

Does child resist tooth brushing? YES NO Does he/she like taking a bath? YES NO

Swings? YES NO Parties? YES NO Rough housing? YES NO

Child's prefers to play: alone other children older children younger children with adults

Is your child overly sensitive to loud sounds? YES NO Bright lights? YES NO

Tags on clothing? YES NO

Does your child have difficulty falling asleep? YES NO Staying asleep? YES NO

SPEECH, LANGUAGE, AND HEARING DEVELOPMENT

Do you feel your child has a speech problem? YES NO

If yes, please describe:

_____

_____

Has he/she ever had a speech evaluation or had speech therapy? YES NO

If yes, where and when? _____

What were you told? _____

What was he/she working on? _____

What other evaluations/therapies has your child received (physical therapy, occupational therapy, counseling, vision, etc.)?

_____

Is your child aware of, or frustrated by, any speech/language difficulties?

_____

_____

What do you see as your child's most difficult problem in the home?

_____

At what age did the child say his or her first word(s)? _____

Did speech learning ever seem to stop for a period of time? YES NO

If yes, explain: _____

Circle all that apply:

Child talks: a lot occasionally never

Child most frequently uses: sounds single words 2-3 word sentences 3+ word sentences

Is your child difficult to understand? YES NO

Does your child seem to understand what is said to him/her? YES NO

Does your child make appropriate eye contact? YES NO

Does you child ever have trouble remembering what you have told him/her? YES NO

Current speech/language/hearing

Does your child…

Repeat sounds, words, or phrases over and over? YES NO

Understand what you are saying? YES NO

Retrieve/point to common objects upon request (ball, cup, shoe)? YES NO

Follow simple directions ("shut the door" or "get your shoes")? YES NO

Respond correctly to yes/no questions? YES NO

Respond correctly to who/what/where/when/why questions? YES NO

Your child currently communicates using: (circle)

body language sounds (vowels, grunting) words ("shoe", "doggy", "up")

2-4 words 4+ word sentences other _____

BEHAVIORAL CHARACTERISTICS

Circle all that apply:

Cooperative Attentive Willing to try new activities Stubborn

Plays alone for reasonable length of time Easily frustrated/impulsive Restless

Poor eye contact Easily distracted/short attention destructive/aggressive

Withdrawn Inappropriate behavior self-abusive behavior

STATEMENT OF THE PROBLEM

Describe what problem(s) your child is having with motor development, sensory processing, or behavior:

_____

_____

_____

Does your child have any speech, language, or hearing disorders or challenges? YES NO

If yes, please describe:

_____

_____

_____

List any other concerns you have regarding your child's development:

_____

_____

_____

Does your child have a formal diagnosis? YES NO

If yes, what is it?

_____

_____

When was it made? _____ By whom? _____