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Case History Form

Identifying and Family Information:

Child's Name: _____ Birthdate: _____ Sex: ☐ M ☐ F

Child Lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent ☐ Adoptive Parents
☐ Parent and Step-Parent ☐ Other _____

Other children in the family:

Name	Age	Sex	Grade	Developmental Delays

Is there a language other than English spoken in the home? ☐ Yes ☐ No
If yes, which one? _____
Does the child speak the language? ☐ Yes ☐ No
Does the child understand the language? ☐ Yes ☐ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

Birth History

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Was the pregnancy full-term? ☐ Yes ☐ No If no, how may weeks gestation? _____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

First smile _____ said first words _____
Rolled over _____ put two words together _____
Sat alone _____ spoke in short sentences _____
Walked _____ toilet trained _____

Does your child…

☐ choke on food or liquids?
☐ currently put toys/objects in his/her mouth?
☐ brush his/her teeth and/or allow brushing?

When did you start becoming concerned about your child's development, and why? _____

_____
_____

Medical History

Has your child had any of the following:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Chicken Pox
- ☐ Colds
- ☐ Ear Infections

How many? _____
How often? _____

- ☐ Ear Tubes

When? _____

- ☐ Encephalitis
- ☐ Flu
- ☐ Head Injury
- ☐ High Fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleeping Difficulties
- ☐ Thumb/finger sucking habit
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Vision Problems
- ☐ Vision Therapy
- ☐ Sensory Integration Dysfunction
- ☐ Cleft Lip/Palate
- ☐ Autism/PDD Diagnosis
- ☐ Other _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No
If yes, why? _____
_____
Please list any medications your child takes regularly: _____
_____

Behavioral Characteristics

- ☐ Aggressive
- ☐ Attentive
- ☐ Cooperative
- ☐ Destructive
- ☐ Easily Distractible
- ☐ Shy
- ☐ Easily Frustrated
- ☐ Impulsive
- ☐ Inappropriate Behavior
- ☐ Plays alone
- ☐ Poor eye contact
- ☐ Tactile Defensive
- ☐ Restless/fidgety
- ☐ Self-abusive Behavior
- ☐ Separation Difficulties
- ☐ Short attention span
- ☐ Stubborn
- ☐ Withdrawn

School History

If your child is in school, please answer the following:
Name of school: _____
Number of years completed at this school: _____ Teacher's name: _____
Does your child have an IEP (Individualized Education Plan) or 504 plan? ☐ Yes ☐ No
If yes, please attach the current plan.

Hearing Speech-Language

Do you feel your child has a hearing problem? ☐ Yes ☐ No
If yes, please describe: _____
_____
Do you feel your child has a speech problem? ☐ Yes ☐ No
If yes, please describe: _____
_____
Has s/he ever had a hearing evaluation/screening? ☐ Yes ☐ No
If yes, where and when? _____
What were you told? _____
Has s/he ever had a speech-language evaluation/screening? ☐ Yes ☐ No
If yes, where and when? _____

What were you told? _____

_____

Has s/he ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was s/he working on? _____

Is your child aware of, or frustrated by, any hearing or speech-language difficulties? _____

_____

_____

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

_____

What do you see as your child's most difficult problem in school? _____

_____

Occupational/Physical Therapy

Do you feel your child has difficulty with gross or fine motor activities? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Has s/he ever had an occupational or physical therapy evaluation? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

Did your child ever receive Occupational or Physical Therapy? ☐ Yes ☐ No

If yes, where and when: _____

Please describe: _____

_____

Has your child received any other evaluation or therapy? ☐ Yes ☐ No

☐ Vision ☐ Neurological ☐ Psychological

☐ Counseling ☐ Other _____

Please describe: _____

_____

_____

_____

Additional Comments

Please use the space below to let us know anything else you would like for us to know about your child.

_____

_____

_____

_____

_____

_____