Child Case History Form

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Does the child live with the birth parents: (CIRCLE ONE) YES NO

Reason for Referral:

_____

_____

Brothers and Sisters (include names and ages):

_____

_____

What is the primary language of the child? _____

Are there any other languages spoken in the home? _____ If so, what language? _____

Does the child present a speech-language, nutritional, fine motor, feeding, swallowing, weight, sensory, or hearing concern? Please explain.

_____

_____

_____

Does anyone in your family have similar concerns? Please explain.

_____

_____

Is your child currently receiving any other therapy in the community? If so, what type and where?

_____

_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____

_____

Initial: ___

When was the problem(s) first noticed? By whom?

_____

_____

Is the child aware of the problem(s)? If yes, how does he or she feel about it?

_____

_____

Prenatal and Birth History

Mother's general health during pregnancy (Illnesses, accidents, medications, etc…)?

_____

_____

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth Weight:_____

Medical History

Provide the approximate ages at which the child had the following illnesses and conditions:

Asthma _____ Measles _____

Croup _____ Pneumonia _____

Ear Infection _____ Tinnitus _____

Headaches _____ Colds _____

Mastoiditis _____ Draining Ears _____

Has the child had any surgeries or diagnostic tests? If yes, what type and when:

_____

_____

Describe any major accidents or hospitalizations.

_____

_____

Is the child taking any medications? If yes, please identify.

_____

_____

Developmental History

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

Crawl _____

Sit _____

Stand _____

Walk _____

Feed Self _____

Dress Self _____

Use Toilet _____

Use single words (e.g. no, mom, doggie)_____

Combine words (e.g. me go, daddy shoe) _____

Name simple objects (e.g. dog, car horse) _____

Ask simple questions (e.g. Where's doggie?) _____

Engage in a conversation _____

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

_____

_____

Family Medical/Psychological History

Please list family members with these diagnoses

Autism: _____

ADHD: _____

Bi-Polar Disorder: _____

Depression: _____

Schizophrenia: _____

Anxiety: _____

OCD: _____

ODD: _____

Other: _____

Has the patient experienced recent physical/emotional trauma or major life changes (i.e. divorce, deaths, moving, etc.)? If yes, please explain.

_____

_____

_____

_____

Initial: ___

Patient's strengths/Weaknesses:

_____

_____

_____

_____

Patient's challenging behaviors (tantrums, verbal protest, elopement, aggression, self-interest behavior, etc…):

_____

_____

_____

_____

Patient preferences and familiar things:

_____

_____

_____

Top three goals/areas you would like to see change/improve for your child over the next six months:

1._____

2._____

3._____

Person completing form: _____

Relationship to client: _____

Signed: _____ Date: _____

Initial: ___