Children's Hospital of The King's Daughters Health System

**Physical, Occupational and Speech Therapy Case History Form**

Dear Parent/Caregiver:

Please complete the following Case History Form. Please give the form to the evaluating therapist upon arrival for your initial OT/PT/ST evaluation. Thank you in advance for your time.

**Date:** _____
**Name of person completing Case History Form:** _____
**Relationship to child:** _____
**Language(s) spoken in the home:** _____

Please list or briefly describe the concern and goals you have regarding your child's development:

_____
_____

**IDENTIFYING INFORMATION/ FAMILY HISTORY:**

**Child's Name:** _____ Date of Birth: _____ Age: _____
Address: _____
City/ State: _____ Zip: _____
Phone Number: _____ Alternate Phone Number: _____

**Caregiver's Name:** _____ Age: _____
Address: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____

**Caregiver's Name:** _____ Age: _____
Address: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____

**Please list siblings in the home**: _____

**Please briefly describe any family member's significant developmental problems**:
_____

**Educational Information:**

Your child's school: _____Phone:_____
Grade: _____ Teacher's Name: _____
Does your child receive special education services, PT/OT/ST? If so, please include length of time per day: _____

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**Please list any concerns that were voiced by the staff regarding your child's performance, general development or behavior**:

_____

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**MEDICAL/DEVELOPMENTAL INFORMATION:**

Referring Physician: _____Phone_____
Primary Care Physician: _____Phone_____

**Please describe your child's birth history. List any complication during pregnancy, birth, or infancy**:

_____
_____

Birth Weight: _____ pounds _____ ounces **APGAR** scores: _____
Please list any childhood illnesses and/or medical conditions: _____
_____
_____

**Please list any childhood illnesses or medical conditions (past and present)**:

_____
_____

**Please list any current medications and reason for medication**: _____
_____
_____

**Please list any allergies** (Environmental, food, diet restrictions): _____
_____

**Please list any surgical procedures and/or hospitalizations** (include dates): _____

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**Does your child suffer from chronic ear infections**? Please describe frequency and treatment: _____
_____

**Has your child had a formal eye examination**? Please describe: _____
_____

**Has your child had a hearing test? Has your child had tubes in his/her ears, hearing aids, or cochlear implant**? Please describe: _____

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**Please record the approximate age at which your child was first observed doing the following skills**:

| **Speech Skills** | **Age** | **Motor Skills** | **Age** |
|---|---|---|---|
| Babbling | | Sitting unassisted | |
| Imitation of sounds | | Crawling | |
| First word | | Walking | |
| 2-word utterance | | Drinking from cup | |
| Phrases/ Sentences | | Spoon feeding self | |
| Reaching | | Chewing solid food | |

**UNDERSTANDING LANGUAGE/ COMMUNICATING:**
**Does your child react or respond to sounds? When you talk to your child, how much does he/she understand** (a few words, phrases, directions)? Please describe:
_____
_____

**How does your child usually let you know what he/she wants** (cries, points, makes sounds, few words, stretch sounds/long sentences, facial tension, stutter)? Please describe: _____
_____

**SOCIAL BEHAVIOR:**
**Please describe any social concerns** (short attention span, interaction with children and adults, overly active, aggressive behaviors): _____
_____
_____

**FEEDING/ SWALLOWING:**
**Please describe any feeding and/or swallowing concerns** (difficulty biting/chewing, accepting new foods/textures): _____
_____

**CHILD OBSERVATIONS**:
**Please describe how your child ascends/descends the stairs**: _____
_____

**Has your child established a hand preference**? Right ___ Left___

**Please describe how much help, if any, your child requires with self-care skills** (dressing, bathing, feeding, etc. _____

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**Please describe your child's balance skills and motor coordination**:

_____

_____

_____

**Please describe any sensory issues/concerns** (sensitivity to touch, smell, and sound, gets dizzy and/or tires easily, avoids/craves messy activities):

_____

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**Please list any activities that your child particularly enjoys or things that may be useful as rewards**:

_____

_____

**ADDITIONAL COMMENTS:** Please write any further comments that you feel may assist the therapist:

_____

_____