Premier Pediatric Therapy
"Lighting the way to a brighter future"

Case History

General Information

Today's Date _____

Child's Name _____ Date of Birth: _____ Gender_____

Primary Diagnosis: _____

Primary Language: _____

Mother's Name: _____ Phone: _____

Father's Name:_____ Phone: _____

Does the child live with both parents?_____

If no, with whom does the child live? _____

Brothers and Sisters (include names and ages):_____

Referred By:_____ Phone: _____

Address: _____

Physician:_____ Phone: _____

Address: _____

Therapies currently receiving: _____

Other specialists who have seen the child:_____

How does the child primarily communicate?

☐ Gestures ☐ Sign Language ☐ Single Words ☐ Short Phrases ☐ Sentences

Describe the child's developmental/behavioral concerns _____

_____

When was the problem first noticed?_____

Who first noticed the problem? _____

Goals of the parent/caregiver for the child:

_____

_____

Prenatal and Birth History

Describe mother's general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.). _____

Born at _____ weeks gestation Prematurity: yes ☐ no ☐

Child's general condition: _____ Birth weight: _____

Circle type of delivery: ☐ vaginal ☐ cesarean

Did your child require NICU care?: _____ Length of stay at hospital: _____

Significant birth, medical, surgical history: _____

_____

Medical History

Child's general health is judged to be: Good ☐ Fair ☐ Poor ☐

Please check if your child has experienced the following illnesses and conditions:

Adenoidectomy ☐	Asthma ☐	Allergies ☐
Chicken pox ☐	Colds ☐	Convulsions ☐
Croup ☐	Draining ear ☐	Dizziness ☐
Ear infections ☐	Epilepsy ☐	Encephalitis ☐
German measles ☐	Headaches ☐	Hearing loss ☐
Heart problems ☐	High fever ☐	Influenza ☐
Measles ☐	Mastoiditis ☐	Meningitis ☐
Mumps ☐	Noise Exposure ☐	Pneumonia ☐
Seizures ☐	Sinusitis ☐	Tinnitus ☐

Tonsillitis ☐ Tonsillectomy ☐ Visual Problems ☐

Other _____

List child's current medication(s): _____

_____

Any known allergies: _____

Does your child wear glasses?: _____ Hearing aides?: _____

Does your child have a history of ear infections?: _____

Has your child had tubes placed in the ears?: _____

Describe any major accidents, surgeries, or hospitalizations the child has had: _____

_____

_____

Developmental History

Write the approximate age when the child began to do the following.

Crawl _____ Sit _____ Stand _____ Walk_____ Feed Self _____

Dress Self_____ Use toilet _____ Use single words_____ Combine words _____

Name simple objects _____ Use simple questions _____ Engage in a conversation _____

Does the child have any motor difficulty, such as walking, running, or participating in other activities?

which require small or large muscle coordination? _____

_____

_____

General Behavior and Social Background

Does the child eat well? _____ Sleep well? _____

How does the child interact with other family members? _____

_____

Is the child: attentive_____ extremely active_____ restless_____ lethargic _____

Does the child bang his/her head, rock, or spin?: _____

Does the child prefer to play by him/herself?: _____

Preferred activities/toys: _____

How does the child interact with other children?:

_____

Does the child lose his/her temper?: _____

If so, what do you believe to be the trigger these behaviors?: _____

With whom does the child spend most of the day?: _____

Educational History

School or Preschool: _____ Grade:_____

Have there ever been any behavior concerns?: _____

Describe any special services your child receives. _____

_____

* If enrolled for special education services please provide a copy of their most current Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP).

Child's Current Level of Function

Sensory Processing
Does your child seem over or under sensitive/responsive to sensory input?

Tactile:
- ☐ Does not tolerate clothing tags/seams/fabrics
- ☐ Distress during grooming (brushing teeth, combing hair, washing hands)
  - If so, which activity: _____
- ☐ Dislikes being held or touched
- ☐ Likes big, hard hugs
- ☐ Dislikes getting messy
- ☐ Dislikes/avoids certain textures: _____
- ☐ Likes going barefoot
- ☐ Picky eater
  - Foods/textures tolerated: _____
  - Foods/textures avoided: _____

Visual:
- ☐ Covers eyes in bright light
- ☐ Avoids eye contact

Auditory:
- ☐ Responds negatively to loud sounds

- ☐ Dislikes noisy environments
- ☐ Covers ears with hands to protect from sounds
- ☐ Difficulty maintaining focus with noisy background
- ☐ Speaks loudly

Vestibular:
- ☐ Dislikes fast movements
- ☐ Dislikes riding in car
- ☐ Avoids swings/playground equipment
- ☐ Appears anxious when feet leave ground
- ☐ Enjoys fast movements, swings/playground equipment

Sensory Modulation:
- ☐ Difficulty with transitions
- ☐ Difficulty with changes in routine
- ☐ Sensory Seeking/Repetitive behaviors: _____
- ☐ Difficulty self-soothing when upset
- ☐ Exhibits high/low activity level

Sensory Integration:
- ☐ Appears clumsy/uncoordinated
- ☐ Impaired bilateral motor coordination
- ☐ Poor body awareness
- ☐ Difficulty with motor planning
- ☐ Poor proximal stability
- ☐ Poor spatial awareness

Self-Care Skills

Please check the box which best describes your child's self-care skills:

	Independently	With little help (up to 25%)	With some help (up to 50%)	With a lot of help (up to 75%)	Dependent (requires 100% assistance)
TAKE OFF:					
Socks	☐	☐	☐	☐	☐
Shoes	☐	☐	☐	☐	☐
Pants	☐	☐	☐	☐	☐
Shirt	☐	☐	☐	☐	☐
PUT ON:					
Socks	☐	☐	☐	☐	☐
Shoes	☐	☐	☐	☐	☐
Pants	☐	☐	☐	☐	☐
Shirt	☐	☐	☐	☐	☐
FASTEN:					

Velcro	☐	☐	☐	☐	☐
Buttons	☐	☐	☐	☐	☐
Zipper	☐	☐	☐	☐	☐
Snaps	☐	☐	☐	☐	☐
Shoe laces	☐	☐	☐	☐	☐
MEALS:					
Finger feed	☐	☐	☐	☐	☐
Use fork	☐	☐	☐	☐	☐
Use spoon	☐	☐	☐	☐	☐
Use knife	☐	☐	☐	☐	☐
Drink from cup	☐	☐	☐	☐	☐
GROOMING:					
Brushing teeth	☐	☐	☐	☐	☐
Combing hair	☐	☐	☐	☐	☐
Washing hands	☐	☐	☐	☐	☐

Please add any additional information you feel might be helpful in the evaluation or treatment of your child:

_____

_____

_____

_____

Person completing the form: _____

Relationship to the child: _____

Thank you for taking the time to complete this form