315 Oak St. Suite 200, Hood River, OR 97031
Phone: (541)386-0009 Out of Area: 1-866-665-0009
Fax: (541)386-0029

CHILD CASE HISTORY FORM - Adolescent

Thank you for completing this information so that we may provide the appropriate assessments needed. KIDSENSE requests this information for the sole purpose of completing your evaluation. Completion of this form is required prior to your scheduled evaluation.

GENERAL HISTORY:

CHILD'S NAME:	DATE OF BIRTH:	AGE:
PERSON PROVIDING INFO:	TODAY'S DATE:	SEX:
CHILD'S ADDRESS:	REFERRED BY:	
HOME PHONE NUMBER: CELL PHONE NUMBER: EMAIL:	PRIMARY CARE PHYSICIAN: PHONE #:	

Does your child have any current diagnoses? Yes / No **If Yes**, list:	Any falls, significant injuries or surgeries? Yes / N o **If Yes**, list:

Please describe the reason for evaluation and child's current problems:____

____

____

____

____

This problem started on ____________________and is related to ____ illness _____ fall ____accident_____other:___________________________

Testing for this condition: ______x-ray_______CT scan______MRI______Audiology_______other:_____________________________________

Other specialists seen for evaluation or treatment for these issues? Please describe below with names and time lines:

____

____

Any other conditions this child may have: ____

____

THERAPY PRECAUTIONS-Please be specific

Does your child have any food allergies or any other allergies you are aware of? (ex. Latex)	Y	N	Describe:
Are there any movement restrictions? (ex. Atlantoaxial instability if child has Down's Syndrome, etc.)	Y	N	Describe:
Are there any precautions not listed above that we should know about? (dietary restrictions…)	Y	N	Describe:

MEDICATION

Current Medications:	Reasons:

FAMILY HISTORY

Father's Name:	Age:	Occupation:
Mother's Name:	Age:	Occupation:
Is client adopted?	If so, at what age, and from where/what country?	

Are parents (circle one): Married Living together Separated Divorced Remarried

Who lives in the house with this child, other than the parents? (If children are listed, please give names and ages)

Have there been any instances of the following in the child's immediate or extended family members: (Please Circle)

ADHD Learning Disabilities Communication Disorders Autism/PPD Hearing loss Genetic Disorder Stuttering OCD Bipolar Disorder Sensory Issues Other:

MEDICAL HISTORY

			Comments
Ear Infections?	Y	N	
Hearing aid?	Y	N	
Hearing Evaluation completed?	Y	N	Date: Results:
Need for eyeglasses?	Y	N	
Ocular motor/ eye problems?	Y	N	
Serious illness, injury, or falls?	Y	N	Dates:
Frequent colds or sinus problems?	Y	N	
Upper respiratory infections?	Y	N	

PREGNANCY AND BIRTH HISTORY

			Comments
Was pregnancy full term?	Y	N	
Any medications taken during pregnancy?	Y	N	
Any complications with pregnancy? or delivery?	Y	N	
Any special care required at birth? (i.e. oxygen, intubation)	Y	N	

SENSORY

Over sensitive to textures (clothing, toothpaste, sand, etc.)?	Y	N
Initiates movement activities and is active?	Y	N
Avoids movement activities and is sedentary?	Y	N
Seeks activities that are intense like contact sports, carnival rides?	Y	N
Gets car sick or dizzy easily?	Y	N
Seems clumsy?	Y	N
Picky eater regarding textures, smells or tastes?	Y	N
Eats a variety of meats, fruits, vegetables?	Y	N
Over react_________ under-react _________ to sounds?	Y	N
Overwhelmed in busy environments? (grocery store, mall, party)	Y	N
Difficulty falling asleep or staying asleep?	Y	N

SELF CARE SKILLS

Desire to do self care independently?	Y	N
Dress independently including fasteners/shoes?	Y	N
Bathes independently and regularly?	Y	N
Manages hair and clips nails independently?	Y	N
Completes chores and routines at home?	Y	N
Knows how to deal with a basic first aid emergency?	Y	N
Has a routine for homework?	Y	N
Can get own food, make a sandwich?	Y	N
Can order own food from a restaurant?	Y	N
Can manage money to pay for items?	Y	N
Can walk to a friends house independently?	Y	N

BEHAVIORS

Poor attention?	Y	N
Engages in risky behavior?	Y	N
Difficulty with change in the environment or transitions?	Y	N
Rigid about routines?	Y	N
Manages time effectively?	Y	N
Over-reactive?	Y	N
Shuts down?	Y	N
Difficulty with authority figures?	Y	N
Lack of self initiative?	Y	N
Fails to perform difficult tasks?	Y	N
Refusal to perform directed tasks?	Y	N

SOCIAL SKILLS

Struggles with making friends?	Y	N
Maintains friendships?	Y	N
Participates in group activities with friends?	Y	N
Resolves small issues with peers independently?	Y	N
Understands and follows social rules?	Y	N
Reads facial expressions well?	Y	N
Empathizes with others feelings?	Y	N
Is socially isolated?	Y	N
Is bullied or taken advantage of?	Y	N

MOTOR

Approximate height ______________ Weight ______________					
Amount of time child participates in physical activities:					
Amount of screen time (computer, Wii, Nintendo DS, TV, etc) spent at home per day:					
Which hand does your child prefer? Right Left Ambidextrous					
Has a dominant hand?	Y	N	Writes legibly?	Y	N
Cuts precisely?	Y	N	Can sew on a button?	Y	N
Can throw and hit a target?	Y	N	Can hit a ball with a bat?	Y	N
Can ride a bike?	Y	N	Can use a pogo stick?	Y	N
Can jump off a surface?	Y	N	Can jump rope?	Y	N
Can swim?	Y	N	Can run long distances?	Y	N
Can dance with rhythm?	Y	N	Can participate in a sport?	Y	N
Regularly physically active?	Y	N	Drives a car?	Y	N

SPEECH AND LANGUAGE

Describe any speech and language concerns:____

____

Does your child have difficulty understanding directions / auditory information? Yes / No If Yes please describe:_______________________________

____

____

VALUES AND BELIEFS

How does your child see him/herself? ____

Are there any specific family medical or health beliefs we should know about? Yes / No If **Yes** please explain:_______________________________

____

Are there any religious beliefs you would like us to know about? Yes / No If **Yes** please explain: _______________________________

____

Any significant fears? Yes / No If **Yes** please explain:____

EDUCATIONAL BACKGROUND

Name of School _______________________________ Home Schooled? Yes / No If **Yes**, how long?__________ Grade Level ________________

How would you describe your child's academic success?____

Are there specific subjects that are difficult for your child (if yes, which ones)? _______________________________

What techniques or approaches in therapy or at home HAVE worked well in the past?_______________________________

What techniques or approaches in therapy or at home HAVE NOT worked well in the past? _______________________________

Please list your child's strengths and interests, including leisure activities:_______________________________

____

Is there anything else you would like us to know about your child? _______________________________

____

What are your goals for your child in therapy? ***Please be specific***_______________________________

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How did you hear about Kidsense? ____

Thank you for completing this form. We understand that this is a lot of information. We require that it is returned to the clinic at least **2 days prior to the assessment.** This information is pertinent to the assessment process. It allows us to be able to spend as much time with your child during your scheduled time and will help us complete the assessment process more accurately and completely.