pediatric therapy center
315 Oak St. Suite 200, Hood River, OR 97031
Phone: (541)386-0009 Fax: (541)386-0029

CHILD CASE HISTORY FORM 8+ YEARS

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 ADDRESS:	PHYSICIAN: PHONE #:	
Does your child have any current diagnoses? List:	Any falls, significant injuries or Surgeries: List:	

Please describe the reason for evaluation/ main concerns:

- ☐ Fine Motor
- ☐ Gross Motor
- ☐ Speech
- ☐ Language
- ☐ Sensory
- ☐ Mobility
- ☐ Feeding
- ☐ Behavior

Please explain your concerns:_____
_____
_____
_____
_____
_____
_____

THERAPY PRECAUTIONS-Please be specific

Does your child have any food allergies or any other allergies you are aware of? Please list.	**Y**	**N**	
If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?	**Y**	**N**	
Are there any precautions not listed above that we should know about? Please describe: (latex allergies, dietary restrictions…)	**Y**	**N**	

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: ☐ 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: ☐ ADHD ☐ Learning Disabilities ☐Communication Disorders ☐Autism/PPD ☐Hearing loss ☐ Genetic Disorder ☐ Stuttering ☐OCD		

MEDICAL HISTORY

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

PREGNANCY AND BIRTH HISTORY

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**	

Please circle any concerns that you have about your child's development:

Fine Motor Skills	Play Skills	Attention	Understanding their Language
Overall Coordination	Sensory Issues	Completion of Tasks/Routines	Ability to Express Themselves
Strength/Balance	Social Skills/ Interaction Others	Oral Motor Skills	Not Talking
Independence with Self-Care	Behaviors	Feeding	Understanding Directions

Please circle any behaviors that your child may exhibit:

Refusal to Perform Difficult/Directed Tasks	Hitting/Biting/Throwing Items
Tantrums	Shuts down
Difficulty Separating	Refusal to Imitate
Short Attention	Other:

Does/Is Your Child:

Self Care Skills (as age appropriate)

Need help with dressing?	**Y**	**N**
Complete fasteners (snaps, zippers, buttons, tie shoes)?	**Y**	**N**
Selecthis/her own clothing?	**Y**	**N**
Show desire to do self-care tasks independently?	**Y**	**N**
Know &follow routines and sequential tasks?	**Y**	**N**
Rigid about his/her routine?	**Y**	**N**
Recognize and avoid danger?	**Y**	**N**
Have a typical response to pain?	**Y**	**N**

Sensory

Have difficulty with change in the environment or transitions?	**Y**	**N**
Overwhelmed in new busy environments? (Grocery,Mall)	**Y**	**N**
Have difficulty falling asleep independently? Staying asleep?	**Y**	**N**
Over sensitive to textures? (clothing, toothpaste, sand)	**Y**	**N**
Get car sick? Avoid movement activities?	**Y**	**N**
Seek constant motion / movement?	**Y**	**N**
Over react to sounds? or Under react to sounds?	**Y**	**N**
Have difficulty maintaining personal space / boundaries?	**Y**	**N**

Attention

Does your child understand simple 3 step routine directions?	**Y**	**N**
Can your child follow multiple stepdirections? (pick up your toy, put in the drawer, and then come here)	**Y**	**N**
Can your child show interest or interact with others on a variety of topics?	**Y**	**N**

How long will they attend to an activity not of their choosing? _____ minutes Choice activity? _____ minutes

Motor

Which hand does your child prefer? ☐ Right ☐ Left ☐ Ambidextrous

Check the items your child is able to do: independently

☐ throw a ball to a person ☐ catch a ball from 3 ft, 5 ft, 8 ft ☐ roller skate ☐ swim

☐ monkey bars ☐ climb up and down a ladder ☐ ride a bike ☐ alternate feet down the stairs

☐ jump up &down ☐ hop on one foot ☐ skip ☐ jump rope ☐ kick a ball

Check those that apply: ☐ tires easily ☐ overly active ☐ clumsy ☐ looses balance ☐ uses surfaces for support

Speech & Language

What percentage of your child's speech do you understand?
Does your child make speech sounds incorrectly? ☐ YES ☐ NO If so, which ones?
Please provide the approximate age your child began doing the following: Began babbling/cooing _____ Used single words _____ Combined words _____ Asked simple questions _____ Engaged in conversation _____ Named simple objects _____ Does your child understand what is said to him / her?: ☐ YES ☐ NO If no, describe? What is the primary language spoken in the home? _____ Does the child speak any other languages? ☐ YES ☐ NO If yes, list them:_____ Please describe your child's speech – language problem:

Social Skills

Does your child make friends?	**Y**	**N**
Does your child maintain friendships?	**Y**	**N**
Does your child participate in pretend or creative play?	**Y**	**N**
Does your child play with peersin reciprocal (back and forth) play?	**Y**	**N**
Does your child use good eye contact?	**Y**	**N**
Is your child cooperative at home/school?	**Y**	**N**
Can your child empathize with other's feelings? (he's happy, sad… with more elaboration if older child)	**Y**	**N**
Does your child join in group play successfully?	**Y**	**N**

Feeding/Oral Motor

Does your child eat a balanced variety of fruits, vegetables, meats and breads? ☐ YES ☐ NO
List foods your child craves: _____
Have you intentionally eliminated any foods from your child's diet? ☐ YES ☐ NO If yes, describe:_____
Is your child on a special and/or restricted diet? ☐ YES ☐ NO If yes, describe _____

EDUCATIONAL BACKGROUND

Name of School _____/home schooled?
Grade Level _____
Reading Level _____
Name of Teacher _____
How would you describe your child's academic success?_____
Are there specific subjects that are difficult for your child (if yes, which ones)? _____
Does your child currently receive therapy at school? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐Special Education
Therapist's names _____ May we communicate with school staff? Y / N

Has your child previously seen any other specialists or received therapy other places besides school? Please describe below:

_____

_____

Please list your child's strengths & interests: _____

_____

What do you do for fun together, as a family?_____
Is there anything else you would like us to know about your child? _____

_____

What are your goals for your child in therapy?

_____

_____

_____

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.