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

CHILD CASE HISTORY FORM 0-8 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)

Toilet-trained?	**Y**	**N**
indicate need to use toilet independently?	**Y**	**N**
Select his/her own clothing?	**Y**	**N**
Show desire to do self-care tasks independently?	**Y**	**N**
Know & follow routines and sequential tasks?	**Y**	**N**
Rgid about his/her routine?	**Y**	**N**
Recognize danger?	**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?	**Y**	**N**
Avoid movement activities?	**Y**	**N**
Over react to sounds? or Under react to sounds?	**Y**	**N**

Attention

Does your child understand simple 1 step routine directions? (sit down/ come here)	**Y**	**N**
Can your child follow multiple step directions? (pick up your toy, put in the drawer, and then come here)	**Y**	**N**
When looking at a book or pictures, do they show interest or interact with story characters in the book?	**Y**	**N**

How long will they sit for a story? ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes

Motor

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

Check the items your child is able to do: independently

☐ roll ☐ sit ☐ crawl ☐ walk ☐ throw a ball to a person ☐ catch a ball ☐ kick a ball

☐ alternate feet down the stairs ☐ jump up & down ☐ hop on one foot ☐ skip

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

Speech & Language

Receptive Language

Does your child respond to sounds in the environment (voices, telephone...)?	**Y**	**N**
Does your child respond to words like "stop" or "wait"?	**Y**	**N**
How many parts of a multi-step direction can your child complete *independently?* Example: 1) go to your room, 2) get your shoes, and 3) bring them to me ☐ 1 ☐ 2 ☐ 3		
Does your child point to named pictures in a book ("where is the _____")?	**Y**	**N**

Expressive Language

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 _____ How does your child usually communicate? (gestures, words, phrases, sentences): _____		
Does your child try to gain your attention to show you things or make requests?	**Y**	**N**
Does your child imitate your actions, sounds or words?	**Y**	**N**
Does your child make speech sounds incorrectly? Y N If so, which ones?		
What percentage of your child's speech do you understand? (e.g. 50%, 75%...)		

What is the primary language spoken in the home? _____
Does the child speak any other languages? Y N (if yes, list them)_____

Social Skills

Does your child easily make friends?	**Y**	**N**
Does your child maintain friendships?	**Y**	**N**
Does your child participate in pretend play?	**Y**	**N**
Does your child play with peers in 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 you child still use a pacifier?	**Y**	**N**
Does your child drink from a sippy cup?	**Y**	**N**

Feeding/Oral Motor

List 3 meats your child will eat: _____
List 3 breads/starches that your child will eat: _____
List 6 vegetables/fruits that your child will eat: _____
Is your child on a special and/or restricted diet? Y N (If yes, please 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: _____
_____
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.

315 Oak Street,Ste 200
Hood River, OR 97031
Phone: 541.386.0009

FINANCIAL RESPONSIBILITY FORM

Complete all sections of this form, read the acknowledgement and any related documents, and sign/date

PATIENT'S INFORMATION

LAST NAME_____FIRST NAME_____NICKNAME_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
HOME PHONE#_____ CELL PHONE #_____EMAIL_____
DATE OF BIRTH _____ SEX _____ SS#_____ EMPLOYER_____
PREFERRED METHOD OF CONTACT_____ MAY WE SEND YOU KIDSENSE UPDATES/INFO VIA EMAIL? YES / NO
PRIMARY CARE PHYSICIAN_____ PHYSICIAN PHONE#_____
REFERRED BY _____REFERRAL SOURCE PHONE#_____

EMERGENCY CONTACT INFORMATION

NAME_____ RELATION TO PATIENT_____
ADDRESS_____PHONE #_____

FINANCIAL RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT) ***SIGN BELOW***

NAME_____ RELATION TO PATIENT_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
HOME PHONE#_____ CELL PHONE #_____EMAIL_____
SS#_____EMPLOYER_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE#_____
PRIMARY INSURED'S NAME _____RELATION TO PATIENT_____
PRIMARY INSURED'S ID# _____ PRIMARY INSURED'S DATE OF BIRTH_____
PATIENT'S ID# (IF DIFFERENT THAN PRIMARY INSURED'S)_____
GROUP # _____ PLAN NAME / TYPE _____PAYOR ID _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE#_____
PRIMARY INSURED'S NAME _____RELATION TO PATIENT_____
PRIMARY INSURED'S ID# _____ PRIMARY INSURED'S DATE OF BIRTH_____
PATIENT'S ID# (IF DIFFERENT THAN PRIMARY INSURED'S)_____
GROUP # _____ PLAN NAME / TYPE _____PAYOR ID _____

FINANCIAL RESPONSIBILITY - ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION & ACKNOWLEDGEMENT OF PATIENT POLICIES:

By signing below, you acknowledge that:

You have read and agree with the following:

- Financial Policy*
- Patient Policies
- Privacy Practices

Kidsense will check on insurance benefits as a courtesy, however it is ultimately the Financial Responsible Party's responsibility to know the insurance benefits, including any exclusions and/or limitations in coverage.

Kidsense reserves the right to change these policies and will inform you of any changes in writing within 30 days of implementation.

Signature of Financial Responsible Party_____ **Date**_____

Print Name_____

Consent for Occupational / Physical / Speech Therapy /Massage Treatment and Child's Medical Information

In presenting my son/daughter for evaluation and treatment

Name: _____for (name of child): _____
Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter ☐

of _____ years of age, hereby voluntarily consent to the rendering of such care, including evaluation, re-evaluation and treatment, by authorized members of Kidsense staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents

I hereby give my consent to Kidsense who will be treating my child (Name of Child) _____ for Occupational, Physical, Speech, and Massage Therapy as necessary for the well-being of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Parent 1: _____

Address: _____

_____

Telephone no: _____

Email: _____

Parent 2: _____

Address: _____

_____

Telephone no: _____

Email: _____

Family Physician: _____

Pediatrician: _____

Surgeon: _____

Orthopedist: _____

Child's allergies, if any: _____

_____

_____

Medications child is taking: _____

_____

Signature: _____ Date: _____
Parent/Guardian/Authorized Representative

In case of emergency I can be reached at: _____

Please supply any additional important information:

_____

_____