Initial Case History Form

Please help us learn about your child. Fill this form out prior to the initial evaluation.

Date completed: _____ Completed by: _____ Relationship:_____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Referred by (name/title): _____

Pediatrician's Name _____ Physician's phone number: _____

Home Address: _____

Primary phone number: _____ Secondary phone number: _____

Child lives with: ☐Both Parents ☐ Mother ☐ Father ☐ Shared custody ☐Other: _____

Sibling's Names and ages: _____

Primary language spoken at home by parent/guardians: ☐ English ☐ Spanish ☐Other: _____

Child's preferred/primary language: ☐ English ☐ Spanish ☐Other: _____

What is your primary concern? _____

Birth/Developmental History

How many weeks gestation? _____ Child's birth weight? _____

Vaginal or C-section? _____

Were there complications during pregnancy? ☐yes ☐ no during labor? ☐yes ☐ no

if *yes*, please explain: _____

_____

Did your child stay in the NICU? ☐yes ☐ no

if *yes,* please explain: _____

Please tell us when your child met the following developmental milestones:

Task	Age
babbled	
first words	
put two words together	
rolled	

Task	Age
sat without support	
crawled	
stood without support	
walked without support	

Medical History

Does your child have a formal diagnosis? ☐yes ☐ no

If *yes,* please list type and date of diagnosis

_____

Is there family history of speech, language, fluency, learning, hearing, feeding or motor issues? ☐yes ☐ no

If *yes,* please detail family member and difficulty.

_____

Has your child had any of the following:

☐Adenoidectomy

☐Allergies (Please list _____)

☐Breathing Difficulty

☐Ear Infections (How many? _____ Last Occurrence?_____)

☐Ear Tubes

☐Hearing Loss

☐High fevers

☐Head Injury

☐Measles/Mumps

☐Seizures

☐Tonsillectomy

☐Vision Problems

☐Reflux

☐Asthma

Other serious injury/surgery? ☐yes ☐ no

If *yes,* please explain the injury/surgery and when it occurred?

_____

Has your child ever been seen by the following specialists?

☐Audiologist (Hearing)

☐Psychologist/Psychiatrist

☐ENT

☐Gastroenterologist

☐Ophthalmologist (Vision)

☐Nutritionist

☐Neurologist

☐Other: _____

If *yes,* please explain result of evaluation below:

_____

_____

Is your child currently taking any medication? ☐yes ☐ no

If *yes,* please list type and dosage of medication.

_____

Does your child have any dietary restrictions? ☐yes ☐ no

If *yes,* please explain. (gluten-free, limited sugar intake, etc.)

_____

School/Therapy History

Does your child attend school? ☐yes ☐ no

School Name: _____ Grade: _____

Does your child have an IEP with the schools? ☐yes ☐ no

What is your child's classroom setting? ☐regular/mainstream ☐ cluster ☐pull-out

Is your child having any specific difficulties in school? ☐yes ☐ no

If *yes,* please explain. (reading, math, writing, paying attention, behavior, etc)

_____

Has your child ever received the following therapies in any facility/school?

☐Speech-Language Therapy ☐Current – Where? _____☐Past - Where? _____

☐Occupational Therapy ☐Current – Where? _____☐Past - Where? _____

☐Physical Therapy ☐Current – Where? _____☐Past - Where? _____

☐Behavioral Therapy ☐Current – Where? _____☐Past - Where? _____

☐Counseling/Psychology ☐Current – Where? _____☐Past - Where? _____

☐Social Skills ☐Current – Where? _____☐Past - Where? _____

☐Early Steps ☐Current – Where? _____☐Past - Where? _____

☐Other: _____ ☐Current – Where? _____☐Past - Where? _____

Speech and Fluency

Do you have trouble understanding your child's pronunciation? ☐yes ☐ no

What percentage of your child's speech do you understand? _____

What percentage of your child's speech do others understand? _____

If you ask your child to repeat themselves, does their pronunciation improve? ☐yes ☐ no

Does your child stutter? ☐yes ☐ no

If *yes*, please explain how often they stutter (every word, every sentence, etc) _____

If *yes*, do you notice any of the following behaviors during stuttering moments?

☐ blinking ☐ head jerking ☐ grimacing ☐body movements (tapping, rocking, leg shaking)

Feeding/Oral Motor

What is your child's primary source of nutrition? ☐regular table foods ☐ purees ☐liquids ☐ g-tube

Has your child had a swallow study? ☐yes ☐ no

If *yes,* please explain results: _____

Does your child:

Cough or choke frequently when they eat or drink? ☐yes ☐ no

If *yes*, please state the frequency and what specific foods/liquids they tend to choke on.

_____

Eat crunchy foods *(*i.e., crackers, chips*)*? ☐yes ☐ no

Eat soft foods (i.e., bananas, bread)? ☐yes ☐ no

Eat pureed foods (i.e., apple sauce, yogurt)? ☐yes ☐ no

Eat chewy foods (i.e. meat, granola bar?) ☐yes ☐ no

Have difficulty chewing or swallowing certain foods? ☐yes ☐ no

If *yes,* please list any concerns: _____

Highly prefer one texture/flavor/temperature over others? ☐yes ☐ no

If *yes,* please list any concerns: _____

Has your child had recent changes in weight gain or loss? ☐yes ☐ no

If *yes,* please list any concerns: _____

Suck their thumb, finger or pacifier? ☐yes ☐ no please specify: _____

What does your child drink from? *Please check all that apply*. ☐bottle ☐ sippy cup ☐open cup ☐ straw

Does your child use the following utensils to feed themselves?

Finger feed	☐independently	☐with help	☐not attempting
Spoon	☐independently	☐with help	☐not attempting
Fork	☐independently	☐with help	☐not attempting
Fork and knife to cut	☐independently	☐with help	☐not attempting

Social/Play Skills

Does your child:

Stop play or an activity when you call his/her name?	☐yes ☐ no ☐ sometimes
Look for the person who is talking?	☐yes ☐ no ☐ sometimes
Respond to words such as “no”, “wait”?	☐yes ☐ no ☐ sometimes
Follow simple, familiar directions without help? (*i.e.: sit down, close, open, come here)*	☐yes ☐ no ☐ sometimes
Wave hello or goodbye independently ?	☐yes ☐ no ☐ sometimes
Mouth toys or non-food items?	☐yes ☐ no ☐ sometimes

Play with toys functionally? (cars, blocks, books, figurines?) ☐yes ☐ no ☐ sometimes

Play pretend? (play food, dress-up)? ☐yes ☐ no ☐ sometimes

Play turn-taking games? (catch, board games) ☐yes ☐ no ☐ sometimes

Play well with peers and/or siblings? ☐yes ☐ no ☐ sometimes

Seek attention from familiar adults? ☐yes ☐ no ☐ sometimes

Respond to social questions (name, age, grade)? ☐yes ☐ no ☐ sometimes

Make friends easily? ☐yes ☐ no ☐ sometimes

Does your child use eye contact in play? ☐yes ☐ no ☐ sometimes

Please list any additional opportunities your child has to engage with peers *(ie: sports teams, social groups, after school care, regular play dates with friends or family, faith based community opportunities, etc.)*

_____

Please list your child's favorite toys, songs, or motivators that can be used during therapy *(i.e., music, toys, games, etc.).*

_____

Behavioral Characteristics

Please check all that apply:

☐ curious of environment	☐impulsive	☐ withdrawn
☐ attentive	☐ destructive/aggressive	☐easily frustrated
☐ easily distracted	☐self-abusive behavior	☐ willing to try new activities
☐ playful	☐difficulty separating from parents	☐affectionate
☐ cooperative	☐difficult to calm when upset	☐fearful

Please indicate any other concerns you have for your child's behavior below:

_____

Activities of Daily Living

Does your child put shoes on the correct feet? ☐yes ☐ no ☐ sometimes

Does your child brush their own teeth? ☐yes ☐ no ☐ sometimes

Is your child toilet trained? ☐yes ☐ no ☐ working on training

Is your child able to wipe themselves independently after bowel movement? ☐yes ☐ no ☐ sometimes

Dressing- Does your child take off/on the following items:

	Off	On
Socks	☐independent ☐with help ☐no attempts	☐independent ☐with help ☐no attempts
Shoes	☐independent ☐with help ☐no attempts	☐independent ☐with help ☐no attempts
Bottoms	☐independent ☐with help ☐no attempts	☐independent ☐with help ☐no attempts
Pull-over shirt	☐independent ☐with help ☐no attempts	☐independent ☐with help ☐no attempts
jacket	☐independent ☐with help ☐no attempts	☐independent ☐with help ☐no attempts

Does your child complete the following fasteners *independently?*

Zipper

Hook two ends together ☐yes ☐ no ☐ sometimes

Zip up and down ☐yes ☐ no ☐ sometimes

Large Front Buttons

Unbutton ☐yes ☐ no ☐ sometimes

Button ☐yes ☐ no ☐ sometimes

Snap Front Buttons

Unbutton/pull apart ☐yes ☐ no ☐ sometimes

Button/snap together ☐yes ☐ no ☐ sometimes

Belt Buckle

Unfasten ☐yes ☐ no ☐ sometimes

Fasten ☐yes ☐ no ☐ sometimes

Loop through belt loops ☐yes ☐ no ☐ sometimes

Shoe Laces

Tie ☐yes ☐ no ☐ sometimes

Lace ☐yes ☐ no ☐ sometimes

Please indicate any other concerns you have for your child's self-care development.

_____

Sleep/Rest Routine

What time does your child go to sleep at night? Weekdays? _____ Weekends? _____

What time does your child wake up in the morning? Weekdays? _____ Weekends? _____

Does your child stay asleep through the night? ☐yes ☐ no ☐ sometimes

Does your child take a nap during the day? ☐yes ☐ no ☐ sometimes

Does your child have any specific nap/sleep time objects they need in order to sleep? ☐yes ☐ no

If *yes,* please indicate (ie: nightlight, music, teddy bear/doll, blanket, thumb sucking, etc.)

_____

Please indicate all concerns you have for your child's sleep/rest routine.

_____

Safety Awareness

Does your child:

Have difficulty identifying familiar vs. unfamiliar adults? ☐yes ☐ no ☐ sometimes
Approach/engage with strangers to the point where it is unsafe? ☐yes ☐ no ☐ sometimes
Seem unaware of personal space (kissing, standing too close)? ☐yes ☐ no ☐ sometimes
Run away or wander in public? ☐yes ☐ no ☐ sometimes
Seem unaware about handling dangerous objects? ☐yes ☐ no ☐ sometimes

Gross Motor Skills

Is your child able to?

Run easily without falling ☐yes ☐ no ☐ sometimes

Jump with both legs leaving the ground ☐yes ☐ no ☐ sometimes

Climb ladders/playground equipment ☐yes ☐ no ☐ sometimes

Throw a ball using one hand ☐yes ☐ no ☐ sometimes

Catch a ball with both hands ☐yes ☐ no ☐ sometimes

Kick a softly rolling ball ☐yes ☐ no ☐ sometimes

Is your child able to walk **UP** stairs? ☐yes ☐ no

Do they need to hold on for support? ☐yes ☐ no ☐ sometimes
Do they alternate feet with each step? ☐yes ☐ no ☐ sometimes

Is your child able to walk **DOWN** the stairs? ☐yes ☐ no

Do they need to hold on for support? ☐yes ☐ no ☐ sometimes
Do they alternate feet with each step? ☐yes ☐ no ☐ sometimes

Does your child walk on their toes? ☐yes ☐ no ☐ sometimes

Do you notice your child sitting in a “w-sitting” position?  ☐yes ☐ no ☐ sometimes

Please indicate any other concerns you have for your child’s gross motor skills.

_____