Child Case History

Date: _________________________
Child's Name: ___________________________________
Address: ____
____ Tel: _______________
Date of birth: _______________ Place of birth: ________________________
Referred by: ____
Name of person completing form: ____
Relationship to child: ____
Physician Name & practice address: ____
____
Insurance Information: ____
Language(s) spoken at home by child: ____
by parent or caregiver: ____

FAMILY

Father:
Name: _____________________________ Age: ______________
Lives with family? ____________ Occupation: ___________________
Employment: ____
Telephone (Home): ___________________ (Cell): __________________

Mother:
Name: _____________________________ Age: ______________
Lives with family? ____________ Occupation: ___________________
Employment: ____
Telephone (Home): ___________________ (Cell): __________________

Brothers and sisters:

(Name)	Age	(Name)	Age
___________________	_______	___________________	______
___________________	_______	____________________	______
___________________	_______	____________________	______

Medical, Developmental and Family History

Pregnancy & Delivery

Mother's age at time of delivery: ___________
Mother's health during pregnancy: ___________________

Describe difficulties (if any) during pregnancy:

____

____

Type of delivery: ___________________

Child's health following delivery: ____

Mom's health following delivery: ____

____

Did baby accompany Mom home from hospital? _________________________________

Developmental

At approximately which age did the child:

Sit: ________ Crawl: _______ Walk: _______

Babble: _______ Use single words: _______

Combine 2 words: _______ Use Phrases: _______ Use sentences: _______

Is your child a picky or fussy eater?

Check the foods he tolerates below:

Soft ____ Chewy ____ Crunchy ____ Sticky ____ Cold _____

Sweet ____ Sour ____ Warm ____

Parental Concerns

Describe any development problems during early childhood (i.e., late walking, feeding problems, food allergies, late in talking) __________________________

____

Please describe your concerns regarding your child's speech, language, feeding, play and social development.____

____

Is your child aware of this problem and does it lead to frustration? ________________

Have your child ever received any type of therapeutic services (PT, OT, ST etc.) If yes please name of service, where it took place, when it occurred and outcome.

____

____

____

List any present physical disabilities.____

Any chronic illnesses, allergies or physical conditions?_______________________________

____

Vision normal? _____ Hearing normal? ______

Do other members of the family have speech, language, or reading problems or learning disabilities? If so please describe. ____

<u>School and Social History</u>

Name & address of school:

____

____

Leisure time activities ____

What specific questions do you have about your child that you would like us to try and answer? ____

____

____

What goals would you like to see accomplishes as a result of this evaluation? _________

____

____

If, in order to help your child, it is appropriate to send reports to other agencies or professional persons, or to contact other agencies and professional persons, please indicate your permission by signing below.

I authorize and request John Peats to obtain or exchange pertinent medical/educational information. I understand that all information will be kept confidential.

Name: ____

Relationship to child: ____

Date: _________

Signature: ____