



Confidential Case History Questionnaire

Identifying Information

Child's Name: _____ Date of Birth: _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Person to Contact in Case of an Emergency: _____ Phone Number: _____

Diagnosis (if known): _____

Primary Physician/Pediatrician: _____

Physician's Phone Number: _____ Fax Number: _____

Other Physicians/Specialists/Professionals working with your child

Name	Specialty	Phone Number

Insurance Information

Insurance Company: _____

Person Insured: _____ Date of Birth: _____

Insurance Address: _____

Insurance Phone Number: _____

Group Number: _____ Policy Number: _____

Medicaid Number: _____

Referral Information

Referred by: _____

Describe your concerns and nature of the problem: _____

Has your child received any PT, OT, ST services up to this date? _____ If yes, when and where?

Family Background

Mother's Name: _____ Age: _____

Occupation: _____ Education Level: _____

Father's Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: single married divorced separated widowed

Sibling(s) of Child at Home:

Name	Age

Education Information

Is your child currently enrolled in school? Yes No If "Yes", school name and days of week attended:

If "Yes", what grade/classroom level: _____

Does your child receive any services through the school? Yes No

If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP)? Yes No

If enrolled in school, is your child considered to have difficulty with any of the following?

Reading Math Spelling Organizing work

Handwriting Finishing tasks Remembering information

Restlessness Following directions Other: _____

Medical History

Prenatal

Is your child adopted? Yes No If yes, at what age? _____

Did mother have any infections, illnesses, injuries, or other complication during pregnancy?

Yes No If yes, please describe: _____

Any medications taken during pregnancy or delivery? Yes No If yes, please list:

Birth and Infancy

Location of Birth: _____ Birth weight: _____

Was pregnancy full term? Yes No If no, how many weeks? _____

Was labor (check all that apply) normal short prolonged induced

Was delivery (check all that apply) normal breech caesarean forceps used

Was child incubated? Yes No If yes, how long? _____

Were there any complications at birth? (check all that apply) jaundice transfusions

breathing difficulty feeding difficulty Apgar score: _____

Other: _____

Describe any congenital defect: _____

As an infant did the child seem: (check all that apply) happy cry frequently sleep long hours

wake often feed slowly eat well like being rocked fuss when held colicky

difficult to get to sleep difficult to hold/cuddle need to be held/unable to self calm

As an infant, did your child dislike lying on stomach? Yes No

did your child dislike lying on back? Yes No

did your child enjoy bouncing? Yes No

did your child become calmed by car rides or infant swings? Yes No

did your child become nauseated by car rides or infant swings? Yes No

Does or did your child:

Have trouble learning urinary control? Yes No

Have trouble learning bowel control? Yes No

Continue to have accidents: during the day? Yes No; at what age did they stop? _____

during the night? Yes No; at what age did they stop? _____

Have difficulty registering need to eliminate? Yes No

Tend to masturbate frequently? Yes No

Sleep Patterns

Does your child:

Have a regular sleep pattern? Yes No If no, describe: _____Wake frequently during the night? Yes No If yes, describe: _____Tend to be an early riser, up and on the go? Yes NoHave a difficult time falling asleep? Yes No**Current Medications**

Name	Dosage	Frequency	Reason for medication

Medical Procedures (Surgeries, serious injury, casts or braces)

Procedure	Date

Does your child have a history of recurrent ear infections? Yes No If yes, has your child had PE tubes placed? Yes No Date last PE tubes placed: _____Any history of seizures? Yes No If yes, how are they treated? _____

Date of most recent: _____

Any known allergies? Yes No If yes, please describe: _____Any diet restrictions? Yes No If yes, please describe: _____Has your child had a hearing test? Yes No Date of last testing: _____

Who was the test performed by? _____ Results of hearing test? _____

Has your child had an eye examination? Yes No Date of last testing: _____

What were the results of the eye exam? _____

Does your child wear glasses? Yes No

Motor Development

Developmental Skill	Age child achieved independently
Roll over	
Sit Alone	
Crawl	
Crawling phase <input type="checkbox"/> prolonged <input type="checkbox"/> brief <input type="checkbox"/> almost entirely eliminated	
Walk	
Chew solid food	
Drink from cup	
Eat with utensils	

Can your child do the following? If yes, indicate the quality of child's performance.

Skill	No	Yes	Poor	Average	Good
Hop on one foot					
Skip with both feet					
Climb on and over objects					
Jump with both feet together					
Ride a tricycle					
Ride a bicycle, with/without training wheels					
Jump rope					
Roller-skate					
Kick a ball					
Pump self on swing					
Cut with scissors					
Color inside lines					
Draw lines and circles					
Build with blocks or other building materials					
Play with puzzles (non-interlocking/interlocking)					
Have consistent hand dominance <input type="checkbox"/> Right <input type="checkbox"/> Left					
Blow soap bubbles					
Blow whistles					
Suck through a straw					

Speech Language Development History

Language

At what age did your child babble? _____

At what age did your child say single words? _____

What were his/her first words? _____

At what age did your child put 2-3 words together? _____

How many words does your child currently use? (check the answer that applies)

0-5 10-20 20-50 50-100 more than 100

What is your child's primary way to make his/her wants or needs known? (e.g. gestures, pointing, sounds, one or two words, etc.) _____

Is your child difficult to understand at times? Yes No

How well is your child understood by: (i.e. what percentage of the time)

Mom: _____ Dad: _____ Younger siblings: _____ Older siblings: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

Does your child understand and/or speak another language other than English? Yes No If yes, what other language(s)? _____

Which is predominant language at home? _____

Any speech or hearing problems in immediate or extended family? Yes No If yes, please explain:

Fluency

Does your child stutter or stammer? Yes No

How long have you observed dysfluencies? _____

Is your child aware/concerned/frustrated? _____

Voice

Does your child's voice exhibit any of the following qualities? (Check all that apply.)

Hoarse Harsh Nasal Very soft Very loud Other: _____

Feeding

Have there been any feeding problems? Yes No If yes, please explain: _____

Are there any problems with sucking, chewing, choking, or swallowing? Yes No If yes, please explain:

Are the child's food preferences a concern? Yes No If yes, please explain: _____

Have there been any problems with liquids? Yes No If yes, please explain: _____

What are some of the foods that are typical in the child's diet? _____

Any foods your child strongly avoids? Yes No If yes, please list: _____

Social Development and Play Skills

Describe your child's personality: _____

Describe any social problems your child has with friends or family: _____

What are his/her favorite activities/toys/games? _____

Does your child play appropriately with these toys? Yes No

How long does he/she play with one toy? _____

Whom does your child prefer to play with? _____

What makes your child smile and laugh? _____

What play activities does your child least enjoy? _____

How does your child play when left alone? _____

What does your child do when angry or frustrated? _____

Does your child tend to play with things by lining them or piling them up? Yes No

Is your child currently enrolled in any community activities (such as music class, play groups, Mother's Morning Out Program)? Yes No If yes, how would you describe your child's behavior compared to other children involved in the activities? _____

Please describe any other concerns you may have regarding your child's social or play skills:

Activities of Daily Living

What self help skills does your child have? (Please use the following letter code:
U- Unable, I- Independent, A- needs assistance, S- needs supervision only)

Skill	Level of Independence	Skill	Level of Independence
Dresses self		Drinks from cup	
Undresses self		Zips zippers	
Toilets self		Buttons	
Brushes teeth		Snaps & hooks	
Washes hands		Puts on shoes	
Feeds self with utensils		Laces shoes	
Cuts with knife		Ties shoes	

Sensory History

Please check the choice that applies to your child: Yes, No, or N/A. Please only check N/A if your child is not yet old enough, or for other reasons, not-applicable. Add additional information in comment section that may be relevant. Remember the more information received, the better picture of your child is created.

Visual

Yes	No	N/A	Question	Comments
			Seem fearful of catching balls?	
			Have difficulty locating objects in drawers, on shelf, or on paper?	
			Draw some numbers and letters backwards?	
			Have difficulty discriminating shapes, colors, etc.?	
			Become easily distracted by visual stimulation?	
			Blink at bright lights or seem irritated by them?	
			Maintain good eye contact?	
			Notice when people enter the room?	

Auditory

Yes	No	N/A	Question	Comments
			Like to sing or dance to music?	
			Seem not to understand what is said at times?	
			Respond to having his/her name called?	
			Have trouble remember what was said?	
			Have speech/articulation difficulties or delays?	
			Follow 2 or 3 step instructions given at once	
			Misunderstand meaning of words in relation to movement or body position?	
			Use proper sentence structure when expressing what he/she wants?	
			Seem overly sensitive to sounds?	
			Become distracted by lots of noise?	
			Seem to make sounds constantly?	
			Become distracted by background noises such as refrigerators, fans, or fluorescent lights?	
			Seem unaware within an active environment?	

Taste/Smell

Yes	No	N/A	Question	Comments
			Explore with smell; deliberately smell objects?	
			Act as though all foods taste the same?	
			Tend to notice even the slightest smells?	
			Seem defensive or overly sensitive to some odors?	
			React aversively to taste/texture of many foods?	

Touch (tactile processing)

Yes	No	N/A	Question	Comments
			Have difficulty eating smooth foods with a few lumps (such as soup)?	
			Tend to examine objects by touching thoroughly with hands (past two years)?	
			Tend not to feel pain as much as others?	
			Seem unaware of bruises and heavy falls?	
			Find small manipulative activities difficult?	
			Tend to drop things easily?	
			Drool frequently?	
			Leave clothing twisted on body?	
			Walk on toes?	
			Seem excessively ticklish?	
			Become irritated by labels/tags in clothing?	
			Prefer to touch rather than be touched?	
			Strongly dislike haircutting and shampooing?	
			Dislike fingernail or toenail cutting?	
			Complain if socks are not on correctly?	
			Seem to crave being cuddled or held?	
			Dislike being touched unexpectedly?	
			Tend to prefer long sleeves and pants regardless of weather?	
			Dislike certain cloth textures?	
			Avoid getting hands into paste, finger paints, or messy things?	
			Often seem overly active?	
			Tend to bump or push others?	
			More sensitive to pain than other children?	
			Become easily bothered by small cuts?	
			Tend to remove shoes whenever possible?	
			Complain that others often hit or push them?	
			Pinch, bite, or otherwise hurt self?	
			Complain about bumps on the bed sheets?	
			Seem to overheat easily?	
			Strongly dislike showers (5 years or over)?	
			Become extremely bothered when splashed with water?	
			Dislike walking barefoot on grass or sand?	

Yes	No	N/A	Question	Comments
			Seem overly sensitive to food or water temperature?	
			Dislike hand and face washing?	
			Dislike holding hands with others?	
			Willingly accept toothbrushing?	
			Dislike wearing adhesive bandages or stickers?	

Proprioception

Yes	No	N/A	Question	Comments
			Dislike having eyes covered?	
			Like playing in the dark?	
			Tend not to alternative feet going down stairs (4 years or older)?	
			Have difficulty petting animals (using too much force)?	
			Tend to lack carefulness, be impulsive?	
			Frequently bump into things (chairs/doorways)?	
			Frequently grasp objects very tightly?	
			Tend to break many objects?	
			Tend to eat in sloppy manner?	
			Have difficulty handling utensils?	
			Frequently spill liquids?	
			Keep mouth open most of the time?	
			Grimace or move tongue while doing fine motor tasks?	
			Step or climb backwards without watching his/her feet (ladders/stairs)?	
			Jump a lot on beds or other surfaces?	
			Bang head on purpose?	
			Prefer crunchy textured foods?	
			Lick, suck, or chew on nonfood items (past 18 months)? If so, please list.	
			Seem to deliberately fall or tumble?	
			Like to be under weighted items (lots of blankets or under the cushions)?	

Vestibular

Yes	No	N/A	Question	Comments
			Have trouble following object with eyes?	
			Seem to have good balance?	
			Ask for more speed (while swinging or rocking)?	
			Enjoy swings?	
			Enjoy merry-go-rounds or fast carnival rides?	
			Avoid climbing on equipment (jungle gyms)?	
			Like being tipped upside down/lifted overhead?	
			Rock in bed?	
			Like to spin self around?	
			Become carsick easily?	
			Become upset if head is tilted backwards as in hair washing?	

Yes	No	N/A	Question	Comments
			Avoid walking on uneven surfaces?	
			Dislike elevators or escalators?	
			Enjoy spinning on swings, sit and spins, etc.?	
			Fall asleep easily in car?	
			Have difficulty calming down after active play?	
			Tend to be in perpetual motion?	

Motor Planning

Yes	No	N/A	Question	Comments
			Tend to prefer to play alone?	
			Strongly desire sameness or routine?	
			Tend to be intense or easily frustrated?	
			Tend to be very set in routines (even time)?	
			Prefer the company of adults to children?	
			Prefer playing with children who are 1 or 2 years younger?	
			Approach new motor activities in an overly cautious manner?	
			Avoid drawing activities?	
			Prefer table activities to playground activities?	
			Move in a slow or plodding manner (dressing)?	
			Take a long time to do most motor tasks?	
			Appear reluctant to participate in gross motor activities (sports, dancing, and games)?	
			Have difficulty with motor tasks that have several steps?	
			Have difficulty maintaining or copying rhythms?	

Strength/Tone

Yes	No	N/A	Question	Comments
			Need to use handrail when going down stairs?	
			Seem shaky when doing fine motor tasks?	
			Seem weaker than others the same age?	
			Tire easily with physical activity?	
			Have difficulty handling eating utensils?	
			Tend to slump while sitting?	
			Tend to move in and out of chair while eating or doing work?	
			Feel heavier when lifted than anticipated?	
			Have trouble chewing?	

Social Adjustment

Yes	No	N/A	Question	Comments
			Make friends easily?	
			Tend to crave attention?	
			Seem sensitive to criticism?	
			Lack self-confidence?	

Yes	No	N/A	Question	Comments
			Have strong outbursts of anger, tantrums?	
			Get along with other children easily?	
			Tend to be quiet and withdrawn?	
			Seem very relaxed and patient?	
			Tend to have difficulty separating from parents?	
			Sometimes hit or bite other children?	
			Seem discouraged or often down?	

Are there any specific questions you have about your child that you would like us to address through our assessment? What would you like for your child to achieve?

Please tell us about your child’s strengths and gifts.

Thank you for your time in completing this comprehensive case history. This information is valuable to the therapist(s) in completion of a thorough assessment of your child.

I understand that I am responsible for payment in full at the time of evaluation/assessment unless other arrangements have been made in advance. I also understand that reports will not be released until payment is complete.

Printed name

Signature

Date

Relationship to child: _____