Client Case History

Date:	
Child's Name:	**Date of Birth:**
Parents/Guardian:	**Home phone:**
Address:	**Email:**
	Cell phone:
Father's Employer:	**Work phone:**
Mother's Employer:	**Work Phone:**
Insurance Company:	**Insured's Name:**
Policy Number:	**Group Number:**
Client's SS#:	**Insured's SS#:**
Referred by:	**Primary Physician:**

Medical History:

Please describe your child's birth history. List any complications during pregnancy, birth or infancy?

Was prenatal care initiated? If so, at what month?

How long was the pregnancy?

Was there any illness or accidents during pregnancy?

How long was the labor?

How long was the child hospitalized after birth?

Was an epidural used?

Is your child adopted?

Does your child know that he or she was adopted?

At what age was he or she adopted?

Was your child breastfed or bottle-fed?

Please check Yes or No and describe:

	Yes	No	Description or at what age		Yes	No	Description or at what age
Adenoidenectomy				Hospitalization			
Allergies				Influenza			
Anoxia				Jaundice			
Asthma				Measles			
Blood Disease				Meningitis			
Chicken pox				Mouth breather			
Cyanosis				Mumps			
Feeding tube				Muscle disorder			
Frequent colds				Nerve disorder			
Croup				PE Tubes			
Dental problems				Plagiocephaly			
Diphtheria				Pneumonia			
Drooling				Rheumatic fever			
Ear infections				Seizures			
Encephalitis				Surgery			
Head Injuries				Tonsillectomy			
Hearing Impairment				Torticollis			
High fevers				Vision impairments			

Please explain further any checked above or if a condition is not listed that you feel is important please describe:

- Describe any major accidents or hospitalizations:

  _____
  _____
  _____

- Does your child have any medical diagnoses (ADD, Autism, Dyslexia, Hearing/Vision Impairment, etc)? If yes, at what age was he or she diagnosed?

  _____
  _____
  _____

- Is your child taking any medications? If yes, please list the dosage, frequency and the condition that is being treated.

  _____
  _____
  _____

Please list the professionals that your child has seen with contact information:

	Name and Phone Number:
Psychologist	
Neurologist	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Allergy Specialist	
Sleep Specialist	
Psychiatrist	
Social Worker	
Educational Specialist	
Developmental Optometrist or Ophthalmologist	
Other	

School History:

Name of School and Teacher:	**Grade:**

Developmental History:

Motor Development:
Please indicate your child's age when they first began the following:

Sat up alone	
Pulled self to standing	
Crawled	
Walked	
Rode tricycle	
Rode bicycle	
Reached for Toy	
Finger fed	
Used utensils to feed self	
Undressed self	
Dressed self	
Buttoned/Zippered	
Tied shoes	

Self-care:
Please describe the level of assistance that you provide with the following self-care activities with 1 being the "least" (the child is independent) to 5 being the "most":

Self-Care Activity	Level of Assistance	Self-Care Activity	Level of Assistance
Tooth brushing		Sits for meals	
Hair washing		Keeps track of own belongings	
Bathing		Organizes homework	
Dressing		Transitions easily	
Haircuts		Toileting skills	

Arousal/Attention/Self-Regulation: *Yes or No?*

Is an early morning riser	
Awakens during the night	
Has difficulty falling asleep	
Is irritable upon waking	
Wets bed	
Attends to toys	
Attends to school	
Attends to new environments	
Able to sustain attention	
Independently explores	
Are there certain times of the day where your child seems happier or more irritable?	

Balance/Body Awareness Praxis: *Yes or No?*

Initiates new activities	
Understands how to play with new toys	
Plays with the same toy in a variety of ways	
Able to perform sequential tasks	
Jumps	
Plays on playground equipment (slides, jungle gym, monkey bars, etc.)	
Swings	
Enjoys rough house play	
Takes risk	
Seems aware of safety concerns	
Can your child descend and climb stairs alternating steps?	
Balance on a balance beam?	
Is your child afraid of heights or movement?	
Does your child get motion sickness in the car?	

Behavioral/Emotional Development:

Compliant	
Displays affection towards others	
Displays aggression towards self	
Displays aggression towards others	
Irritable	
Cries easily	
Seems happy	
Seems immature when compared to peers	
Displays rapid mood swings	
Seems independent	
Seems dependent	
Baby talks	
Seems to need a lot of comfort and nurturing	
Seems impulsive	
Difficult to discipline	
Blames others for own mistakes	
Seems remorseful	

What discipline method(s) work best? _____

_____

_____

_____

Speech and Language Development:

Language(s) spoken in home and/or at school:_____

Age when your child spoke first word:_____

Age when your child spoke combined words:_____

Age when your child spoke in sentences:_____

What was your child's first word(s)?_____

What was your child's first sentence?_____

Which sounds (if any) are incorrect?_____

How many words can your child say? (List if fewer than fifteen)_____

_____

How long are your child's sentences?_____

Does your child have any difficulty understanding you? (Describe) _____

_____

Does your child have difficulty following directions? (Describe) _____

_____

Does he or she initiate eye contact when greeting someone? _____

Initiate eye contact when requesting information?_____

Does your child sustain eye contact? _____

Does your child take turns? _____

Explain how your child interacts with peers and adults_____

_____

How does your child participate in conversations?_____

_____

If your child is non-verbal, please describe the vocalizations or how the child communicates (signing, gestures)_____

_____

Are there any speech or hearing problems in the immediate or extended family (Explain)?

_____

_____

Social Development:

Names and ages of siblings (please note if they live in the home with child or not): _____

_____

Other adults living in the home:_____

Has your child attended day care?_____Preschool?_____

Number of regular playmates:_____ Ages:_____ Genders:_____

Activities shared with parents and siblings: _____

How does your child handle frustration? _____

How does your child handle conflict?_____

How does your child handle separation? _____

Regular responsibilities of child:_____

Favorite places:_____

Favorite people:_____

Favorite Toys:_____

Favorite Snacks: _____

Favorite Activities: _____

Favorite TV programs: _____

What motivates your child most? _____

Does your child play with the same toy in a variety of ways? _____

Parental Concerns:

What have you been told by a doctor, teacher and/or others about your child's abilities and needs?

Self-care/daily routine – typical mealtime, getting dressed, bath time, toileting, transitioning between tasks, completing homework

Reaction to change – new environments, new people, new activities

Cognition – attention, ability to follow directions, recall, decision making and problem solving

Home Environment – house/apt, cluttered/neat, individual bedroom or shared, etc…

What do you see as your child's strengths?

What are your concerns about your child?

What do you hope your child will gain by being seen at Crossway Pediatric Therapy?

Signature: **Date:**