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BlueRidge SPEECH & HEARING

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www.speechhearing.org

PEDIATRIC CASE HISTORY FORM

Occupational Therapy

Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child's every day level of functioning. If you answer yes to any questions please try to give comments.

**Please Note: After completion, please return this form, along with any other pertinent academic/medical information (i.e. IEP, reports from other clinicians or therapists your child has seen) to the center.*

I: Case Information: **Date:** _____

Child's Name: _____

Child's Date of Birth:_____**Age:**_____ **Sex:**_____ **Grade in School:**_____

Father's Name:_____ Mother's Name:_____

Date of Birth:_____ Date of Birth:_____

Father's Address:_____ Mother's Address:_____

_____ _____

Father's Employer:_____ Mother's Employer:_____

Position:_____ Position:_____

Father's telephone (H)_____ Mother's telephone: (H)_____

(W)_____ (W)_____

(C)_____ (C)_____

Email_____ Email_____

Parent's marital Status: S M D W

Child Lives with (check one):

_____ Birth Parents ____Foster Parents _____One Parent

_____Adoptive Parents ____Parent and Stepparent _____Other _____

Ethnicity: African American Asian Caucasian Hispanic/Latino Other_____

Primary Language Spoken in home/ by primary caregiver: _____/_____

Primary Language Spoken by child in home_____ Other Languages Spoken_____

Primary Insurance_____ Phone _____

Address: _____ ID#_____

Card Holder Name: _____ Card Holder DOB _____

Secondary Insurance_____ Phone _____

Address: _____ ID#_____

Card Holder Name: _____ Card Holder DOB _____

AVAILABILITY for Services

mark an X for all time slots that you are available to come for sessions, should services be recommended

	Monday	Tuesday	Wednesday	Thursday	Friday
8-9					
9-10					
10-11					
11-12					
1-2					
2-3					
3-4					
4-5					
5-6					

Please describe why you are having your child seen for an occupational therapy evaluation:

_____

_____

II. Birth History:

Pregnancy	**YES**	**NO**	**Health at Birth**	**Yes**	**No**
1. Did the mother experience any abnormal bleeding, illnesses, injuries or any other medical complications during pregnancy?			9. Was your child pronounced healthy at birth?		
2. Did the mother take any prescription medications, alcohol, cigarettes or drugs?			10. Did the baby experience difficulty breathing at birth? If yes, was oxygen needed?		
3. Was your child adopted? If yes please provide the age they were adopted.			11. Were there any medical complications?		
4. If your child was adopted do they know?			12. Were there any congenital defects affecting the baby?		
Delivery			13. Was the baby jaundice?		
5. Was the delivery premature? If yes, how many weeks?			14. Did the baby spend any extra time at the hospital?		
6. Was medication given to induce labor? If yes, what kind?			15. Was there a need for tube feedings or an IV?		
7. During labor were any instruments used to assist with birth?			16. Was the baby bottle or breast-fed?		
8. What was the baby's gestation age (weeks) and birth weight?	Age	Wgt	17. Were there any complications with feeding?		

Please explain any "yes" answers below (place the question # and then the explanation):

_____

_____

III. Medical History:

	Yes	**No**		**Yes**	**No**
1. Does your child have any medical diagnosis (i.e. ADHD, Autism Spectrum Disorder, Hypotonia, dysgraphia etc.)? Please specify			8. Does your child have a history of ear infections?		
2. Is your child currently taking any medications?			9. Has your child ever been hospitalized or had any type of surgery?		
3. Does your child have any allergies (food, medications, or environmental)?			10. Does your child have a history of stomach or GI problems?		
4. Are your child's immunization record up to date?			11. Has your child ever had any type of physical injury (i.e. broken bone, muscle injury etc.)?		
5. Did any adverse reactions occur from the vaccines?			12. Has your child had a vision exam? Results:	Date	
6. Has your child ever experienced a seizure? If yes please give dates, how often and the type.			13. Has your child had a hearing exam? Results:	Date	
7. Does your child have a history of respiratory or heart problems?			14. Has your child experienced any of the following (please circle): **Meningitis, High Fevers, Chicken Pox, Pneumonia, Tuberculosis**		

Please describe any questions you answered "yes" answers (place the question # and explanation):

_____

_____

IV: Developmental History:

Please note what age your child achieved these milestones, please comment if any were skipped or not yet achieved. Some may not yet be applicable.

	Age		**Age**
1. Roll over both directions		9. Drink from an open cup	
2. Sit independently		10. Did your child start talking and then stop or loose words?	
3. Crawl on hands and knees		11. Demonstrate a hand preference, right or left?	
4. Eat solid foods		12. When did your child become toilet trained?	
5. Cruise around furniture		13. Dress themselves independently	
6. Walk independently		14. Button and zip independently	
7. Speak first word		15. Ride a tricycle	
8. Spoon feed themselves independently		16. Ride a bike without training wheels	

Please comment if there was anything that contributed to a delay in one of the above milestones.

_____

_____

V. Sensory Motor History:

Tactile (Touch) Sensory System Does your child…	**Yes**	**No**	**Comments**
1. mind being touched by others?			
2. startle to being touched unexpectedly (i.e. if someone accidentally brushes against them)?			
3. always have to have their hands clean?			
	Yes	**No**	**Comments**
4. prefer to initiate cuddling or hugging?			
5. mind getting messy or dirty (i.e. playing in sand, finger painting, glue etc.)?			
6. dislike going barefoot? (Is it on certain surfaces such as sand or grass?)			
7. avoid certain textures of clothing (i.e. jeans, sweaters, tighter material etc.)?			
8. dislike grooming activities such as washing their face, brushing hair, hair cut or nails cut?			
9. seem to lack an awareness of touch?			
10. seem to have a need to touch everything and everyone around them?			
11. crave touch from others?			
12. appear to have an abnormally high or low pain tolerance?			
Visual Sensory System Does your child…	**Yes**	**No**	**Comments**
1. stare or look at an object longer than expected?			
2. seem sensitive to bright light?			
	Yes	**No**	
3. tilt their head to the side when looking at an object, reading or writing?			
4. rub or squint their eyes when looking at something?			
5. have difficulty identifying colors			
6. have difficulty discriminating between the size and shape of an object?			
7. dislike closing or covering their eyes?			
8. have difficulty with puzzles?			
9. skip lines when reading or writing?			

Auditory Sensory System Does/is your child….	**Yes**	**No**	**Comments**
1. respond negatively to unexpected or loud noises (i.e. cover ears, run away, become upset, cry etc.)			
2. tend to notice sounds that others don't notice?			
3. ask for the TV or radio to be lowered?			
4. become upset (i.e. cover their ears, cry, ask to leave) in a noisy setting?			
5. distracted easily by background noises?			
6. appear to make noises just to hear themselves?			
7. consistently respond to their name being called?			
8. appear not to hear what you say?			
Proprioceptive System (body awareness) Does your child…	**Yes**	**No**	**Comments**
1. crave jumping or falling into objects or people?			
2. seem to do things either too hard or too light (using either too much or too little muscle force)?			
3. appear to grasp objects either too hard or too light?			
4. play overly rough with others?			
5. seem unaware of how to move their body to do a motor task?			
6. crave hugging and/or cuddling?			
7. crave rough play?			
9. walk into other people, walls or objects ?			
Vestibular System (moving body in space) Does/is your child…	**Yes**	**No**	**Comments**
1. fall frequently or loose their balance easily?			
2. overly cautious on playground equipment or with motor activities?			
3. seem uncomfortable moving in space (i.e. lifting feet off of ground, stairs, heights)?			
4. get carsick easily?			
5. get nauseous and/or vomit from movement (i.e. carnival rides, swinging)			
6. dislike swinging or carnival rides?			
7. dislikes spinning, bouncing, and twirling?			
8. dislike tipping head backwards?			
9. have trouble catching self when falling?			
10. like to climb high and lack safety awareness?			
11. seem to spin and move around more than others?			
12. seem not to get dizzy as much as peers?			
13. in constant motion, difficulty sitting still?			
Postural Control Does/is your child…	**Yes**	**No**	**Comments**
1. have difficulty sitting upright on the floor?			
2. lean on objects or people when standing up?			
3. slump or hold their head in their hand when sitting at a desk/table?			
4. seem weaker than peers?			
5. tire easily with motor tasks/poor endurance?			
6. prefer more sedentary activities rather than playing outside?			
Oral Motor Does/is your child…	**Yes**	**No**	**Comments**
1. crave certain textures of food (i.e. crunchy, soft, chewy etc.)? Please specify			
2. crave certain flavors of food (i.e. sweet, salty, sour etc.) Please specify			

3. have a history of reflux?			
4. gag when eating certain foods or food textures?			
5. chew on non-food objects?			
6. use a pacifier or suck their thumb?			
7. become upset or sensitive to teeth brushed?			
8. require a special diet?			
9. have any feeding problems?			
Gross Motor Skills/Motor Planning Does/is your child…	**Yes**	**No**	**Comments**
1. have slow and deliberate movements with motor activities?			
2. move too fast and loose control?			
3. appear clumsy or awkward?			
4. trouble getting themselves dressed?			
5. enjoy Phys. Ed. and sports?			
6. have difficulty jumping or running?			
7. have difficulty learning new motor skills?			
8. able to jump on one foot?			
9. have difficulty kicking a ball?			
10. have difficulty catching and throwing a ball?			
Fine Motor Skills Does/is your child…	**Yes**	**No**	**Comments**
1. have difficulty with buttons, zippers and snaps?			
2. have difficulty manipulating small toys?			
3. have difficulty holding pencil?			
4. able to identify left and right hands?			
5. have difficulty copying shapes or drawing?			
6. have difficulty coloring within the lines			
7. able to write along a line?			
8. reverse letters when writing?			
9. skip lines when copying a writing sample?			
10. have difficulty with spacing and sizing letters?			
11. complain of being tired when writing?			
12. frustrate easily when writing?			

VI. Behavioral History

Please check all that apply to your child:

Friendly	Inattentive	Shy
Easy Going	Distracted Easily	Prefers socializing with adults
Cooperative	Impulsive	Passive
Attentive	Resists Change	Poor eye contact
Good eye contact	High activity level	socially awkward
Social	Aggressive	Low self-esteem
Flexible	Stubborn	Separation difficulties from parent
Sleeps well	Cries easily	Prefers to play alone
Makes friends easily	Poor sleeper	Echo words spoken to them
Happy	Acts out	
Affectionate	Frustrates Easily	

VII. Education History: School/ Daycare:_____

Does your child receive Special Education Services? If yes, what services?

Please describe your child's school behavior (if applicable).

VIII. Services:
Please list any recent psychological, educational, occupational therapy or speech and language evaluations your child has received. (If you wish to share any of the reports please provide them)

Has your child every received occupational therapy services in the past? If yes, when and where?

IX. Additional Questions
What are you goals for your child to be addressed through occupational therapy services?

What are your child's hobbies and favorite interests?

Please provide any additional information that you believe would help the OT get to know your child.

This form was completed by: _____ Relationship: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

Persons/Organizations receiving the information:

(Please include any /all of the professionals involved in the care of the client for the current diagnosis for which he/she is being seen.) Please include name and phone number. This information will be used to assist in providing the most comprehensive care to the client.

Note: It is very important that you provide us with an address or we may not be able to forward a copy of the report to those requested.

Primary Care Physician /Pediatrician: _____Address_____

Audiologist: _____Address_____

G.I.:_____Address_____

Neurologist: _____Address_____

Physical Therapist: _____Address_____

Occupational Therapist_____Address_____

Speech Therapist: _____Address_____

Other: _____Address_____

Name of School: _____Address_____

Teacher: _____Grade: _____

My signature authorizes Blue Ridge Speech & Hearing Center the disclosure or use of my medical information with the above indicated professionals.

_____ _____

Signature of client or client's representative ***Date***

_____

Printed name of client's representative

_____

Relationship to client