Kids' Village Therapy, LLC
Pediatric Case History Form

This form must be completed and returned prior to the patient's scheduled evaluation time to assist in creating the most effective assessment experience. Please also provide copies of reports from other specialists, including speech-language pathologists, who have evaluated and/or treated your child. Additionally copies of your child's IFSP, IEP and any other information that you feel would be helpful would be appreciated.

GENERAL INFORMATION

Date: _____

Name of person completing this form /relationship to child _____

_____

Child's Name:_____

Date of Birth: _____ _____Male _____ Female

Address:

_____

_____

Telephone: (Home) _____

(Work) _____

Mother's Name: _____

Father's Name: _____

Child's Medical Diagnoses:

_____

Referral

Source:_____

Physician:

_____

Physician's Address:

_____

Physician's FAX: _____
Physician's Phone: _____

Other Physicians who provide care:

Name	Type of Specialist
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT HISTORY

Describe in your own words the type of difficulty your child his having (i.e., what are your specific concerns):

_____
_____
_____
_____

When was the problem first noticed?

_____

Is your child aware of the problem? □ Yes □ No If yes, how does your child feel about it?

_____
_____
_____

FAMILY INFORMATION

Siblings					
Name	Date of Birth	Sex	Grade	Health concerns/ difficulties	Educational concerns/ difficulties

Is there any history of learning, neurological, psychological or hereditary problems in the immediate family or mother/father's families? If so, please describe.

_____
_____
_____

What languages does your child speak (if more than one, please indicate the primary language)? _____
_____

ADOPTION INFORMATION

Is your child adopted? □ Yes □ No
At what age was your child adopted? _____
Where was your child prior to being adopted? (country & setting) _____
_____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any of the following professionals:

PROVIDER	Dates of Exam/Eval	Name of Provider	Currently under Provider's care
Neurologist			□ Yes □ No
Occupational Therapist			□ Yes □ No
Physical Therapist			□ Yes □ No
Speech Pathologist			□ Yes □ No
Psychologist			□ Yes □ No
Orthopedic Physician			□ Yes □ No
Cardiologist			□ Yes □ No
Developmental Pediatrician			□ Yes □ No
Social Worker			□ Yes □ No
Behavior Specialist			□ Yes □ No
Otolaryngologist (ENT)			□ Yes □ No

Is your child currently on any medications? □ Yes □ No
Please list names and schedule of medications:

_____
_____

Please indicate if your child has had any of the following (if not, please write "NO" in the age column):

Illness	Age	Severity	Hospitalized/ Medication	Illness	Age	Severity	Hospitalized/ Medication
Adenoidectomy				Measles			
Allergies				Meningitis			
Asthma				Mumps			
Blood Disease				Muscle Disorder			
Cataracts				Nerve Disorder			
Chicken Pox				Orthodontia			
Cleft Lip/Palate				Pneumonia			
Cross Eye				Polio			
Croup				Respiratory Infection			
Dental Problems				Rheumatic Fever			
Diphtheria				Seizures			
Ear Infections				Scarlet Fever			
Encephalitis				Tonsillectomy			
Headaches				Tonsillitis			
Head Injury				Whooping Cough			
Heart Probs.				Influenza			
High Fever				Mastoidectomy			
Eczema				Vision Problems			
Anoxia				Reflux			

Other:

_____

Has your child had any seizures? Yes No
Age _____
Current medication for seizures?
_____

HOSPITALIZATIONS / SURGERIES

Date	Child's age	Reason for hospitalization	Location	Duration of stay

ALLERGIES:

	Yes / No	To what	Reaction	Treatment
Skin				
Environmental				
Food				
Medications				

Is your child on a special diet? Yes No

If so which one and for how long? _____
_____

Describe your child's strengths:
_____
_____
_____
_____

Does your child show aversive reaction to touching certain objects or textures? Yes No

Does he/she startle easily when touched unexpectedly? Yes No

Describe any problems in bowel or bladder control:

_____

Describe any sleeping problems:

_____

_____

PRENATAL & BIRTH HISTORY

Did the mother require medical intervention to achieve pregnancy?

 Yes No

Please indicate if the mother had any of the following during pregnancy?

Condition	Month of Pregnancy	Hospitalization/ Medications	Condition	Month of Pregnancy	Hospitalization/ Medications
Excessive vomiting			Heart Condition		
Bleeding			Asthma		
Swelling			Thyroid Problems		
High Fever			Kidney Disease		
Toxemia			X-rays		
Rh-Negative Blood			Accidents		
Seizures			Surgery		
Virus Infection			Alcohol Intake		
German Measles			Nicotine		
Diabetes			Drugs		

Were any medication taken during the pregnancy? Yes No
Medications:

_____

Length of Pregnancy _____ Duration of labor _____
Type of Delivery _____
Birth weight _____
What hospital were you in? _____
Were any drugs or anesthetics used during labor?

_____

Were there any problems with the delivery? If so, please describe

_____
_____
_____
_____

How long did your child remain in the hospital?

_____

Describe any medical attention mother or child required.

_____
_____
_____

DEVELOPMENTAL HISTORY

Give approximate age of your child in months or years when he/she accomplished the following:

Smiled _____
Looked at your face _____
Followed objects with eyes _____
Held objects _____
Picked up objects _____
Rolled over _____
Sat alone _____
Belly crawled _____
Crept on hands/knees _____
Stood alone _____

Walked _____
Self fed _____
Dressed self _____
Drank from cup / glass _____
Had bowel control _____
Had bladder control _____

SPEECH & LANGUAGE HISTORY

During the first year, other than crying, how would you describe your child:

A silent baby _____
A very quiet baby _____
An average noisy baby _____
Very noisy baby _____
Please describe his/her vocalizations/sounds:

_____

At what age did he/she say his/her first word?

_____

Did he/she get one or two words and then go a long time before getting any new words? _____

At what age did he/she use two-word combinations like "want cookie"?

_____

At what age did he/she use complete short sentences like "I go upstairs?"

_____

Were these easy to understand? □ Yes □ No

What efforts does (or did) your child make to communicate his/her wants when not understood? _____

_____

_____

_____

_____

Did speech learning ever seem to stop for a period? □ Yes □ No

If so, describe:

_____

_____

How easily can your child follow instructions?

_____

Do you have to frequently repeat instructions? □ Yes □ No

Does he/she seem to have any difficulty hearing? □ Yes □ No

Does he/she have any visual problems? □ Yes □ No

What have you done to help your child's speech and language?

_____

_____

_____

FEEDING DEVELOPMENT/ HISTORY

Were there any feeding problems in the early stages? □ Yes □ No
Please describe:

_____
_____
_____

Describe any current eating / feeding problems (include texture concerns):

_____
_____

Does he/she have difficulty chewing or swallowing? □ Yes □ No

Does he/she drool? □ Yes □ No

When? _____
_____

What does your child eat?

_____
_____
_____

What does your child **not** eat?

_____
_____
_____

Please list any nutritional supplements that your child receives:_____
_____

EDUCATIONAL HISTORY

Indicate the type of setting the child was/currently enrolled:
□ Home □ Home with caregiver □ Day care
□ Preschool □ Kindergarten □ School

List name & location of current school:

_____

_____

Grade Level: _____

Indicate performance level in school:

 Above average Average Below average

List the best/favorite subjects:

_____

_____

List the most difficult/least favorite subjects:

_____

_____

Has your child repeated a grade? Yes No

If so, which grade(s)? _____

Does your child have an

IFSP Yes No

IEP Yes No or

504 plan Yes No

Please indicate any special assistance or services your child receives at school:

SERVICE	**YES/NO**	**NAME OF PROVIDER**
Occupational Therapy	Yes No	
Physical Therapy	Yes No	
Speech Therapy	Yes No	
Adaptive PE	Yes No	
Social Work	Yes No	
Aide	Yes No	
Reading Specialist	Yes No	
LD Resource	Yes No	
Psychologist	Yes No	
Other:	Yes No	