



Pediatric Case History Form

Please complete the following form and bring it to your scheduled evaluation.

Child's Name: _____ Today's Date: _____
Nickname: _____ Date of Birth: _____
Address: _____ Age: _____
City/State/Zip: _____ Phone Number: _____
Parents/Caregivers Names: _____

How/from whom were you referred? _____

What are your current concerns regarding speech, language, mouth movements, motor movements or sensory skills? Please note when the difficulties began. _____

A. Medical History:

1. Does the child currently have a medical diagnosis? If so, please list/describe (please include history of chronic conditions, i.e. congestion/ear infections). _____

2. Who is the child's current pediatrician? _____

3. Has the child ever had surgery or been hospitalized for any reason? Please list. _____

4. Is the child currently taking any medications? Please list. _____

5. Does the child have any known allergies? (medications, foods, latex, seasonal, etc.) Please list. _____

6. Has the child's hearing been evaluated? If so, indicate where, when, and the status of that evaluation. _____

B. Birth History:

1. Was the child born full-term? In not, indicate weeks of prematurity. _____

2. List any complications surrounding the birth/pregnancy. _____

3. Did the child come directly home from the hospital or stay for any reason? Please indicate reason, duration if applicable. _____

C. Developmental History:

1. At what age did the child do the following:

Sit up alone? _____

Complete toilet training? _____

Crawl on all fours? _____

Say first true word? _____

Walk alone? _____

Connect 2 or more words? _____

2. Has your child ever had any difficulty eating (chewing, swallowing, stuffing, pocketing, picky, food aversions, cup use)? _____

3. Does your child have an active or lingering thumb-sucking, finger sucking, or pacifier habit? _____

4. How would you describe your child as an infant (alert/active, difficult to calm, resistant or likes to be held, good or irregular sleep patterns, fussy or irritable, excessive crying, tense or floppy when held, responsive to surroundings)? _____

D. Family History:

1. List who is currently in the child's immediate living environment. _____

2. Is there family history of speech, language, learning, hearing, sensory, motor or mental health issues (ADD, anxiety, etc.)? Describe. _____

E. School/ Therapy History:

1. Does the child currently attend school, daycare, playgroup, etc.? If so, indicate where and how long each week. _____

2. Is the child having any difficulties at school (academically, behaviorally, etc.)? _____

3. Has the child ever received any type of therapy (speech/language, occupational, physical)? If, so indicate which type(s) and durations. _____

F. Social/ Play Behavior:

1. List the child's preferred play activities: _____

2. Does the child...

Engage in pretend play? _____

Play with toys appropriately? _____

Take turns in play? _____

Play with or alongside other children? _____

Make adequate eye contact? _____

Seek out others for interaction? _____

G. Speech/Language Skills:

1. How does the child currently communicate their wants/needs? _____

2. Is the child using gestures and non-verbal language (facial expressions, body language) appropriately? Describe. _____

3. Does the child follow directions? If so, how many steps? If not, describe. _____

4. Do you or others have difficulty understanding your child? If so, describe. _____

H. Reading/Writing History:

1. Does the child have interest in books? Describe. _____

2. Describe the child's current literacy/writing status (reading, recognizing letters, tracing, etc.). _____

I. ADL/Self Help Skills:

1. Do you have any concerns with independent functioning? _____

2. Eating: Indicate yes/no, can the child...
Feed self finger food? _____ Stab food with fork? _____
Bring spoon to mouth? _____ Scoop food with spoon? _____
Cut food with knife? _____ Feed self independently? _____

3. Dressing: Indicate yes/no, Can the child independently...
Take off clothes (shirt, pants, shoes, socks, coat)? _____
Put on clothes (shirt, pants, shoes, socks, coat)? _____
Fasten small buttons, large buttons, or snaps? _____
Zipper up/down? _____
Tie shoes? _____

J. Motor/Sensory Skills:

1. Do you have concerns regarding Gross Motor Skills (i.e. walking, jumping, running, balance, ball skills, physical activities)? If yes, describe. _____

2. Has your child ever had difficulty with body awareness and/or coordination with movement (i.e. appears clumsy, grasps objects too light or too tight, moves very fast or very slow, etc.)? _____

3. Do you have concerns regarding Fine Motor Skills (i.e. holding pencil correctly, manipulation of objects, scissor skills, coloring within the lines)? If yes, describe. _____

4. Do you have concerns regarding your child's handwriting skills (i.e. poor spacing of words, reversals of letters/numbers, mastering cursive, etc)? If yes, describe. _____

5. Has your child ever had difficulty with sensory issues (i.e. respond differently to touch, noise, or smells; crave rough play or touch; bump into objects; not like to get messy; seem fearful of movement)? If yes, describe. _____

6. Does your child have difficulty staying focused/on-task as compared to same-age peers? If yes, describe. _____

K. Therapy Goals:

1. What are your current speech/language related goals/expectations for your child? Do you wish to pursue speech therapy if needed? _____

2. What are your current occupational therapy related goals/expectations for your child? Do you wish to pursue occupational therapy if needed? _____

3. If yes to #1, what are your preferred/available times to bring the child to therapy? _____

4. Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy? _____

5. Please provide any additional information that may be helpful to the evaluation/treatment process:

Completed by: _____ Relationship _____ on _____ (date)

THANK YOU!

Interviewing SLP/OT Signature: _____ Date: _____