CHILD CASE HISTORY

Child's Name:______________________________ Date:__________________

Parent/Guardian:______________________________ Child's Birthdate__________________

Address:______________________________ Phone No:__________________

1. Family Information

	Mother	Father
Biological, Adoptive or Foster		
If Adoptive/Foster, how long has the child lived with you?		
Marital Status		
Occupation		
Level of Education		
Employer		
Work Phone		
Major Illness or Disability? Please List		

Other Persons Living with Child

Name	Relationship to Child	Grade/Occupation	Age	Health/Learning Problems

2. Pregnancy & Birth

	Yes	No	If yes, please explain
Did mother receive prenatal care?			
Were there complications during pregnancy?			
Were there complications during birth?			
Were drugs or alcohol used during pregnancy?			
Was the child born prematurely?			

3. Child's Health

Overall is the child's health ☐ Good ☐ Fair ☐ Poor

Is the child on any medications? If so, please list medication, dosage and purpose:__________________

____

Full name and phone # of child's doctor(s):____

Has the child had any of the following illness?

Disease/Condition	Yes	No	Comments/Complications
Chicken Pox			
Measles			
Mumps			
Rubella			
Cerebral Palsy			
Croup			
Rheumatic Fever			
Pneumonia			
Encephalitis			
Meningitis			
Seizures			
Heart Problems			
Asthma			
Allergies			
Frequent Ear Infections			
Other: Please Specify			
Hospitalizations or Surgeries. Please List			

4. Developmental History

At what age did the child do the following?

Roll Over		Sleep Through the Night	
Sit Alone		Feed Self	
Crawl		Dress Self	
Walk with Help		Toilet Train for Bladder	
Say First Word		Toilet Train for Bowel	
Say First Sentence		Stay Dry Through the Night	

5. Communication

	Yes	No	Comments
Was the child quiet as a baby?			
Was the child noisy as a baby?			
Did the child's speech ever stop for a time?			

	Yes	No	Comments
Is the child aware of a speech problem?			
Has the child's speech changed in the last 6 months?			
Does the child have difficulty understanding speech of others?			
Is another language besides English spoken at home?			What language?
Is the child on a special diet?			
Does the child have trouble chewing or swallowing?			
Has the child ever had a hearing test?			Age/Results
Does the child wear a hearing aid?			
Does the child drool?			
Is the child able to make their needs known?			
Other speech, language, learning or hearing problems in the family? What relation?			

6. Behavioral

	Yes	No	Comments
Does the child have a short attention span?			
Does the child prefer to be alone?			
Does the child lose their temper often?			
Is the child very active?			
Does the child intentionally hurt themself			
Does the child have difficulty sleeping?			
Is the child fearful of strangers or new surroundings?			
Is the child easily frustrated?			

7. Physical

	Yes	No	Comments
Does the child prefer the right or left hand?			
Does the child seem awkward?			
Does the child lose their balance easily?			
Does the child avoid using their hands?			
Is the child orally defensive to certain textures or temperatures of foods?			
Is the child more irritable during bathing? During dressing or changing routines?			

8. Educational

	Yes	No	Comments/Location
Does the child attend daycare?			
Does the child attend school?			
Does the child receive special services at school?			Please list names of providers and location PT: OT: ST: Other (Specify):