Case History

Patient Name: ______________________________
Insurance Name: ______________________________
Insurance Number: ______________________________
Date of Birth: ______________________________

Why are you seeking therapy for your child? ____

____

Current problems (Motor skills, Feeding, Hearing, etc)?

____

Current diagnosis if known?

____

Current medical history?

____

Surgeries and dates (tonsillectomy, tube placement, etc).

____

Major accidents or hospitalizations.

____

Allergies? **If none, please write "O"**

____

Medical History
Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies ________________
Colds ________________
Dizziness ________________
Encephalitis ________________
High Fever ________________
Measles ________________
Pneumonia________________
Tinnitusm ________________

Asthma ________________
Convulsions ________________
Draining Ear ________________
German Measles ________________
Influenza ________________
Meningitis ________________
Seizures ________________
Tonsillitis________________

Chicken Pox ________________
Croup ________________
Ear Infections ________________
Headaches ________________
Mastoiditis ________________
Mumps ________________
Sinusitis ________________
Other ________________

What medications is your child currently taking?

Medication Name	Medical Use	Frequency / Duration

Grade: __________ School: ____
Academic Concerns: ____
Interaction with others (shy, aggressive, uncooperative, etc)? ______________________________
Does your child receive specialized services, or have an Individualized Education Plan (IEP)?

____

Are their any other therapy specialists seeing your child? If so, who and when?

____

Mother's general health during pregnancy (illnesses, accidents, medications, etc).

____

Length of Pregnancy: ___________ Length of Labor: ___________
General Condition: ____________ Birth Weight: _____________
Circle type of delivery: Head First Feet First Breech Caesarian
Were there any unusual conditions that may have affected the pregnancy or birth?

Developmental History
Provide the approximate age at which the child began to do the following activities:

Crawl_____________ Sit__________ Feed Self_________
Walk______________ Stand________ Dress Self________
Use Toilet__________ Use Single Words (no, mom, dad, doggie): ___________

Person completing form: ______________________ Relationship to the child: _____________________
(print name)

Signed: ______________________________ Date: _________________