Advocate Children's Hospital

1775 Dempster Street || Park Ridge, Illinois 60068 || T 847.723.2210 || advocatechildrenshospital.com

PEDIATRIC THERAPIES
Occupational Therapy, Physical Therapy, Speech Therapy
CASE HISTORY – (Confidential)

INSTRUCTIONS: TO ASSIST US IN PROVIDING A COMPREHENSIVE EVALUATION OF YOUR CHILD, PLEASE ANSWER ALL QUESTIONS. PLEASE BRING THE COMPLETED FORM TO YOUR FIRST APPOINTMENT OR MAIL IN THE ENCLOSED ENVELOPE.

A. BACKGROUND INFORMATION

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

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

Address (if different from child's):_____

_____

Mother's Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Father's Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____

Name of Primary Caretaker(s) and relationship of:

_____

Child lives with (include sibling's names and ages): _____

_____

Is there another language, other than English, spoken at home? _____ If yes, which language? _____

Why wwere you referred for this evaluation/therapy/ _____

_____

Who referred you? _____

What are your concerns about your child?_____

Please list your child's medical/developmental diagnosis: _____

_____

Has anyone else in your immediate or extended family had similar problems? Describe: _____

_____

_____

What would you like to learn from this evaluation? _____

_____

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CASE HISTORY – PEDIATRIC THERAPIES

911409

Patient Name: _____
MR Number: _____
Patient Number: _____
OR
Affix Patient Label

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B. PREGNANCY/BIRTH HISTORY

Describe any complication during pregnancy/delivery: _____

Type of Delivery: Vaginal _____ C-Section _____

_____

Pregnancy/Gestation Age: Full Term _____ Pre term ____ (Born at ____ weeks) Late _____ (Born at ____ weeks)
Apgar scores: _____ Length of stay in the hospital: _____
Medical status/complications of the child: _____

C. MEDICAL HISTORY: PLEASE DESCRIBE YOUR CHILD'S PRESENT HEALTH

Childhood History:

Allergies: _____
Childhood Illnesses: _____
Seizures: _____
Hospitalizations / Prolonged Medical Treatment: _____
Surgeries: _____

Does your child use any special equipment / assistive devices? No ____ Yes ____
Does your child have any hearing problems? No ____ Yes ____
Does your child have any vision problems: No ____ Yes ____
Does your child wear glasses: No ____ Yes ____
Does your child wear Hearing Aides? No ____ Yes ____
Any ear infections? No ____ Yes ____ If yes, how many _____

Does your child currently take any medications (including any prescriptions or over the counter or herbal medications)?
If yes, please list below No ____ Yes ____

Medicine Purpose _____
_____
_____
_____

D. DEVELOPMENTAL HISTORY: PLEASE DESCRIBE YOUR CHILD'S PRESENT HEALTH

Motor Development

Age at which child did the following:

1. Lifted head while lying on tummy and held it up alone: _____
2. Reached for and grasped objects: _____
3. Rolled over to tummy: _____
4. Sat without support: _____
5. Crawling: _____
6. Stood Alone: _____
7. Walked with help: _____
8. Walked alone: _____
9. Toilet Trained: _____
10. Rode a bike/tricycle: _____

How does child's development compare with other children in the family? _____

_____ _____

Is the child right-handed? _____ Left handed? _____ Uses both hands? _____

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Feeding: Does your child have difficulty with any of the following?

Chewing	_____	Gagging	_____	Sucking	_____
Drooling	_____	Choking	_____	Slow Feeding	_____
Frequent Vomiting	_____	Picky Eater	_____	Breathing	_____
Feeding Self	_____	Swallowing	_____	Teeth Grinding	_____
Food Allergies	_____	Reflux	_____		

E. SPEECH AND LANGUAGE DEVELOPMENT

1. Other than "crying", how would you describe your baby during the 1st year?
   A silent baby _____ An average noisy baby _____ A very noisy baby _____

2. Used first words at age _____ months. First words were: _____
   _____

3. Used 2-3 word comlbinations at age _____ months.

4. Used complete sentences at age _____

5. Did speech stop for a period of time? _____

6. Is your child aware of his/her speech difficulty? _____

7. Is your child frustrated when he/she speaks? _____

8. Describe how your child communicates: _____
   _____

9. What percentage of speech (25%, 50%, 75%, 90%) is understood:
   by familiar listener? _____ by unfamiliar listener? _____

F. BEHAVIOR – SOCIAL AND EMOTIONAL

Sensory: Does your child respond negatively to touch? No ___ Yes ___ If Yes, please describe:
Does your child respond negatively to sound? No ___ Yes ___ If Yes, please describe:
Does your child respond negatively to movement? No ___ Yes ___ If Yes, please describe:
If yes, please describe:

_____

Please describe:

Discipline (Type, Response, Etc)	
Fears	
Length of time child plays at one activity	
Nervous habits	
Play, Recreation (favorite toys/activities)	
Temperament	

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Please describe:

Relationship to parents	
Relationship fo children of same age	
Relationship to siblings	

G. SLEEPING HABITS

Does your child have difficulty with any of the following? Check all that apply
Length of sleep _____ Bedtime snoring _____ Sleep apnea _____ Bedtime routine _____
What is your child's typical bed time? _____ Wake up time? _____
Please explain: _____

H. EDUCATIONAL DEVELOPMENT

Has your child ever attended preschool, daycare, or a play group program? No _____ Yes _____
Name of current school or program the child is attending: _____
Hours/Day _____ Days/Week _____ Grade _____

If yes, does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?_____

Is your child currently receiving therapy? No _____ Yes _____ If yes, what type?_____
Where does your child receive therapy?_____
Has your child received therapy in the past? No _____ Yes _____ If yes, what type?_____
Where was therapy received? _____
How long did your child receive therapy?_____
List any current extracurricular activities that your child participates in outside of school:

_____
_____
_____

I. ADDITIONAL INFORMATION

Please list all professionals who are or have been involved in your child's care:

	NAME (Print)	PHONE NUMBER
Pediatrician		
Family Medicine		
Neurologist		
Orthopedist		
Psychologist		
Audiologist		
Physical Therapist		
Occupational Therapist		
Speech Pathologist		
Dentist		
Other Physicians		

Date: _____ Time: _____ Signature: _____

Relationship: _____

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