

Professional Therapies, Inc.

Roanoke Vinton Daleville Rocky Mount Moneta Hardy Christiansburg Blacksburg Shawsville

Client Case History

Child's Name: _____ Date: _____

Date of Birth: _____ Sex: _____

Physician: _____ Referred By: _____

Medical Diagnosis: _____

Family History

Mother/Guardian:

Name: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____

Father/Guardian:

Name: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____

Please list any siblings:

Name	Birth Date	Lives in Home

Anyone else who lives in the home:

Name	Age	Relationship

<u>Birth History</u>			
	Yes	No	Comments
1. Were there any illnesses, diseases (exposure to disease), or accidents during pregnancy? Please list.			
2. Did mother take any medications during pregnancy and/or have any history of x-rays?			
3. Type of delivery:	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean		
4. Were there any complications during delivery? Please explain.			
5. Was your child born more than 2 weeks early or late? Please explain.			
6. Did child or mother stay in the hospital longer than usual? Why?			
7. What was your child's birth weight?			Lbs. Oz.

Additional Comments: _____

<u>Medical History</u>			
Has your child had frequent:	Yes	No	Comments
1. Ear Infections			
2. High Fevers			
3. Sore throats			
4. Coughs			
5. Urinary tract infections			
6. Stomach problems			
7. Has your child ever had a seizure? If yes, when? Please describe.			
8. Does your child have trouble with hearing or eyesight? Please explain.			
9. Has your child ever had a serious accident requiring treatment? (broken bones, head injuries, falls, burns, poisoning) Please explain.			
10. Has your child ever been hospitalized or undergone any surgery? Please list reasons and dates.			
11. Is your child currently taking any medication? Please list and explain.			

Medical History

Continued

Has your child had:	Yes	No	Comments
12. Chicken Pox			
13. Measles			
14. Mumps			
15. Scarlet Fever			
16. Are your child's immunizations up to date? Could you provide documentation if needed?			
17. Please list any other medical conditions (e.g. Asthma, allergies, diabetes, etc.)			

Additional Comments: _____

Social History

1. Please list the names of any other agencies or programs in which your child is or has been involved, describing their general performance. (Include any attendance in school.)

Agency	Performance

2. Please describe any special help your child receives from these programs.

Type of Help	How Often	From Whom

3. In your words, please describe your child's personality and behavior.

Developmental History

Hearing			
Does your child:	Yes	No	Comments
1. React to tone of voice by smiling or crying? (infants only)			
2. Turn to the source of a sound? (infants only)			
3. Respond to his/her name and/or no-no?			
4. Talk in a very loud voice?			
5. Turn up the volume on the radio and TV?			
6. Hear you if his/her back is turned?			
7. Hear you if you talk to him/her from another room?			
8. Appear sensitive to or avoid sounds?			
9. Has your child ever had a hearing evaluation? If yes, when and what were the results?			

Additional Comments: _____

Speech and Language			
1. How does your child communicate?			
<input type="checkbox"/> Gestures	<input type="checkbox"/> Word-like Sounds	<input type="checkbox"/> Single Words	
<input type="checkbox"/> Sentences	<input type="checkbox"/> Crying	<input type="checkbox"/> Short sentences	
<input type="checkbox"/> Pointing	<input type="checkbox"/> Other _____		
2. Do you feel you child's speech is:			
<input type="checkbox"/> Easily understood by most listeners?		<input type="checkbox"/> Understood by family & familiar listeners?	
<input type="checkbox"/> Only occasionally understood?		<input type="checkbox"/> Difficult to understand?	
When did your child		Approximate Age	
3. Say his/her first word?			
4. Begin to combine words?			
5. First show signs of difficulties with communication?			
	Yes	No	Comments
6. Do you have difficulty understanding your child? (If yes, what do you do when you cannot understand him/her?)			
7. Do others have difficulty understanding your child? (If yes, how do they react?)			
8. Were there any periods of time when your child's speech decreased or stopped? If yes, please explain.			
9. Does anyone else talk for your child? If yes, who and how much?			

Developmental History

	Yes	No	Began at age:
1. Is your child toilet trained?			
2. Does your child take a nap? If yes, when and how long?			
3. Have there been any big changes in your child's life in the last 6 months? Please explain.			
4. When behavior problems arise, what is the common way of dealing with them?			

Additional Comments: _____

Developmental History

Gross Motor

Does/did your child	Yes	No	Began at age:
1. Roll over from stomach to back?			
2. Rollover from back to stomach?			
3. Hold his/her head without support?			
4. Spend time playing while lying on his/her stomach?			
5. Stand unsupported?			
6. Like to arch his/her back?			
7. Belly crawl (pull self along on stomach)?			
8. Crawl on all 4's?			
9. Walk alone?			
10. Is your child's posture poor or slouched while sitting or standing?			
11. How would you describe your child's balance?	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

Additional Comments: _____

Developmental History

Fine Motor

Does your child:	Yes	No	Began at age/Comments
1. Drink from a cup?			
2. Eat with a spoon?			
3. Play with crayons?			
4. Fasten and unfasten clothing?			
5. Manipulate small objects easily?			
6. Have difficulty with paper and pencil activities?			
7. Shift positions frequently while standing or sitting?			
8. Does one side seem stronger than the other? Which one?			

Additional Comments: _____

Developmental History

Oral Motor

Does/did your child:	Yes	No	Comments
1. Have difficulty eating such as coughing or choking? Please describe.			
2. Have excessive saliva around the outside of the mouth?			
3. Keep their mouth open most of the time?			
4. Have difficulty drinking from a bottle, breast or cup?			
5. Have excessively messy or neat eating habits?			
6. Require assistance with meals? Please describe.			
7. Mouthe objects or fingers excessively?			
8. Does your child still have a bottle or pacifier?			
9. Dos you child chew or eat things other than food?			

Additional Comments: _____

Vestibular ***Movement***

Does/did your child:	Yes	No	Comments
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1. Seem fearful of movement?			
2. Seem unable to sit still for an activity?			
3. Seem to fall frequently?			
4. Like fast moving or spinning rides?			
5. Like playing on swings?			
6. Get sick easily from movement experiences or riding in a car?			
7. Avoid balance activities? What type?			

<u>Tactile</u>			
<i>Perception of Touch, Pain, Temperature</i>			
Does/did your child:	Yes	No	Comments
1. Seem overly sensitive to being touched?			
2. Like being cuddled/hugged?			
3. Seem excessively ticklish?			
4. Seem easily angered or irritated when touched by playmates?			
5. Frequently push or bump into other children?			
6. Isolate from other children?			
7. Tend to touch things or people constantly?			
8. Excessively dislike having hair or face washed?			
9. Avoid certain textures of food? Please give examples.			
10. Dislike the feeling of certain kinds of clothing? Please give examples?			
11. Seem unaware of painful experiences such as shots, stitches, or injuries from playground accidents? Please give examples.			
12. Have a tendency to walk on his/her toes frequently?			
13. Flap hands, clap, jump, hop or stamp feet frequently?			
14. Have irregular sleep patterns? Please describe.			
15. Have difficulty going to sleep or being comforted?			

Additional Comments: _____
