THERA-PLAY, PLLC

Child Case History Form

General Information

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Does the Child Live with Both Parents? _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Age: _____

Father's Occupation: _____ Business Phone: _____

Referred by: _____ Phone: _____

Address: _____

Pediatrician: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Address: _____

Brothers and Sisters (include names and ages):

_____

_____

_____

_____

What languages does the child speak? What is the child's dominant language?

_____

What languages are spoken in the home? What is the dominant language spoken?

With whom does the child spend the most of his or her time?

Describe the child's speech–language problem.

How does the child usually communicate? (gestures, single words, short phrases, sentences?)

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any other speech–language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

Prenatal and Birth History

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?

Medical History

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

Asthma_____ Chicken pox_____ Colds_____

Croup_____ Dizziness_____ Draining ear_____

Ear infections_____ Encephalitis_____ German measles_____

Headaches_____ High fever_____ Influenza_____

Mastoiditis_____ Measles_____ Meningitis_____

Mumps_____ Pneumonia_____ Seizures_____

Sinusitis_____ Tinnitus_____ Tonsillitis_____

Other_____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Developmental History

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

Crawl_____ Sit_____ Stand_____

Walk_____ Feed self_____ Dress self_____

Use toilet_____

Use single words (e.g., *no*, *mom*, *doggie*)_____

Combine words (e.g., *me go*, *daddy shoe*)_____

Name simple objects (e.g., *dog*, *car*, *tree*)_____

Use simple questions (e.g., *Where's doggie?*)_____

Engage in a conversation_____

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

Educational History

School:_____Grade:_____

Teacher(s):_____

How is the child is doing academically (or preacademically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative)?

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form:_____

Relationship to client:_____

Signed:_____Date:_____