Kids Therapy, Ltd

1860 W. Winchester Rd., Suite 108
Libertyville, IL 60048
Phone: (847) 573-9486
Fax: (847) 549-6139

22285 Pepper Road, Suite 301
Lake Barrington, IL 60010
Phone: (847) 842-0597
Fax: (847) 842-9882

Case History Questionnaire

Child's Name________________________________ **Informant**_____________________________
Child's Date of Birth__________________________ **Date**__________________________________

What are your reasons for having your child evaluated?

____

____

____

What do you hope to learn as a result of this evaluation?

____

____

____

BIRTH HISTORY

Please describe the mother's general health during pregnancy (e.g. complications, illnesses, accidents, medications).____

____

____

Length of pregnancy:____________ Duration of labor:___________ Birth Weight:____________

Were there any complications during delivery? No / Yes (If yes, please describe.)_____________________

____

____

How long did your child remain in the hospital after birth? (Please explain any extended hospitalization)_____ ____

____

Describe the general condition of your child as a newborn. (Any health concerns at birth? Difficulty feeding?)

____

____

What form of nutrition did your child receive at birth? Breast Bottle Non-oral

HEALTH/MEDICAL HISTORY

How many ear infections has your child had? ____________________At what age(s)?________________________

How were they treated?____

Has your child had any surgeries (e.g., tonsillectomy, PE tube placement), hospitalizations, and/or serious accidents or illnesses? No / Yes: ____

____

____

Does your child have any **current** medical complications or concerns? No / Yes:____________________

____

____

Does your child have any allergies (**including foods**)? No / Yes: (Please list allergies and how they are managed.)

____

____

Is your child currently taking any medication(s)? No / Yes (if yes, please list medication(s), reason for medication(s), and duration): ____

____

____

Has your child been evaluated by any of the following professionals? (use back of page if you need additional space)

Professional	**Date of Evaluation**	**Results**	**Previously received or currently receiving services? If so, please list dates from and to.**
Physical Therapist			
Occupational Therapist			
Speech-Language Pathologist			
Audiologist (Hearing)			
Vision Specialist			
Psychologist			
Neurologist			
Educational Specialist (LD, Reading)			
Dentist / Orthodontist / Oral Surgeon (outside of routine dental check-ups)			
Gastroenterologist (GI)			
Otolaryngologist (ENT)			
Other:			

DEVELOPMENTAL HISTORY

Gross Motor:

At what age did your child demonstrate the following milestones?
If you are unsure of age, please indicate if you feel it was within age expectations.

	Age of child	**Comments**
Roll		
Sit unsupported		
Crawl		
Walk		
Jump		
Ride a tricycle		

Does your child: fall frequently?____________________ appear clumsy?______________________

Describe your child's: activity level low / average / high endurance level low / average / high

Do you feel your child is impulsive? ____

Does your child have difficulty learning new tasks?____

Please describe any concerns regarding your child's gross motor development.________________________________

____

____

Fine Motor:
Does your child:

	Yes / No	**Has difficulty – please describe**
Reach?		
Point?		
Scribble?		
Manipulate small toys?		
Color?		
Write?		

Does your child use one hand more than another? (If yes, which hand?)______________________________________

Please describe any concerns regarding your child's fine motor development or hand use._______________________

____

____

Self –Help:
At what age was your child potty-trained? Bladder:________ Bowel:_________ Night:________

Does your child have any difficulty transitioning from one activity to another? No / Yes: ______________________

____

Is your child resistive to changes in schedule or unpredictable events? No / Yes: ____________________________

How does your child calm him/herself?____

Does your child have any difficulty sleeping? No / Yes: ____

Does your child help with dressing/undressing? No / Yes: ____

Please describe any concerns you have regarding your child's self-help skills.________________________________

____

____

Sensory:
Please mark either "yes" or "no" to the following questions regarding how your child experiences sensory information, and make any additional comments.

	Yes	No	Comments
Does your child avoid messy play? (i.e. finger painting, sand, paste, etc.)			
Does your child avoid having his/her face or hands washed/wiped?			
Does your child crave jumping, crashing or firm hugs?			
Does your child respond negatively to unexpected or loud noises?			
Does your child appear to ignore some sounds or voices?			
Does your child prefer *strong* tastes? (i.e. sour, salty, spicy, bitter, sweet)			
Does your child chew non-food objects?			
Does your child ignore unpleasant odors or react negatively to smell?			
Does your child squint often?			
Does your child pick up pictures or objects and look very closely and carefully at them?			
Does your child **seek** movement? (i.e. bouncing, turning upside down, spinning)			
Does your child become fearful with some movements? (i.e. swinging, spinning, climbing)			

Attention:
For how long does your child attend to: (please indicate "**too short**," "**average for age**," or "**too long**")
Books:________________ TV/Movie:_____________________ Computer:________________
Preferred toy/activity:_________________ Non-preferred activity:_________________

Speech-Language:
Was your child a (pick one): ___silent baby ____quiet baby ___vocal baby ___very noisy baby

As an infant, did/does your child use a variety of sounds? ____

At what age did your child demonstrate the following?
(If you are unsure of age, please indicate if you feel it was within age expectations.)

	Age of child	Examples / Comments
Babble (i.e. bababa, dabaga)		
Say his/her first words (i.e. no, mom, doggie)		
Begin combining words (i.e. me go, daddy shoe)		
Use sentences (i.e. I want more juice)		
Identify objects		

Did speech and language development ever appear to stop for a period of time?______________________________
Regress? ____

Approximately how many words does your child express? 0-10 10-25 25-50 50-100 100+

How frequently do you understand your child? all the time most of the time some of the time rarely

How frequently do others understand your child? all the time most of the time some of the time rarely

Are any languages other than English spoken at home? No / Yes:

- What language?____
- How often is it used at home?____
- Who uses this language?____
- Is the child around those using this language?___________________________________
- Child's ability to use it?____
- Child's ability to understand it?____

Please describe how your child communicates with you.____________________________________

____

____

Does your child ever become frustrated when trying to speak and/or communicate? No / Yes: (Please describe your child's frustration)____

____

Does your child have difficulty following directions? No / Yes: (Please describe)____________________

____

Does your child use appropriate eye contact when interacting? Yes / No:__________ ___________________

Does your child have a history of thumb sucking or similar behaviors (e.g., finger sucking, use of pacifier or bottle, tongue sucking) *beyond* the age of 3? No / Yes: ____

____

Does your child drool? (If yes, please explain when and if drool is to the level of lip/chin/shirt.)______________

____

Please describe any speech-language concerns you have for your child._________________________

____

____

Social/Emotional:
What are some of your child's favorite toys/play activities? ____________________________________

____

Does your child:

- Initiate interactions with peers?__________________Adults?____________________
- Respond to/participate in interactions with peers?____________________Adults?___________

How would you describe your child within play? leader / follower / observer / aggressor / not interested / other

What opportunities does your child have to interact with peers? __________________________________

____

What activities do you and your child enjoy doing together?____

____

Do you have any concerns regarding your child's emotions or behaviors?_______________________________

____

What do you love most about your child? ____

____

What are your greatest concerns for your child? ____

____

EDUCATION

Is your child currently enrolled in a preschool or school program? Yes / No (If yes, please list district's name, phone number, names of teachers and therapists) ____

____

____

Does your child appear to have any difficulties in school? Yes / No (if yes, please describe) ______________

____

____

Please list any extra-curricular activities that your child participates in (e.g. park district programs, lessons):_______

____

____

FAMILY HISTORY

Is there a family history of:	**Yes**	**No**	**Who?**
Learning disabilities?			
Speech / articulation difficulties?			
Language impairment?			
ADD/ADHD?			
Stuttering/Disfluency?			
Autistic Spectrum Disorders?			
Hearing loss?			
Other ______________________			