Blank Children's Hospital
UnityPoint Health

PEDIATRIC THERAPY CASE HISTORY

Please answer the following questions before your child's evaluation. This information will be used for all therapies: Speech, Occupational and Physical Therapy. Do not complete these white sheets if you have already done so for a previous evaluation. Please notify us if you cannot keep your appointment for the evaluation. Also, please notify us as soon as possible if your phone number, address, or insurance has changed since the appointment was made.

Appointment date(s):
Child's Name: _____ Birth Date: _____
Child's Nickname: _____ Referring Physician: _____
Describe what YOU feel are your child's problem(s). Give examples of your concerns: _____

What are your goals/expectations regarding this evaluation and/or therapy if recommended? _____

Family History Information

Name of Caregiver: _____ Resides with child: ☐ Yes ☐ No
Address: _____ Relation to the child: _____
City/State/Zip code: _____
Home Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Email Address: _____ Best # to reach you: _____
Name of Caregiver: _____ Resides with child: ☐ Yes ☐ No
Address: _____ Relation to the child: _____
City/State/Zip code: _____
Home Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Email Address: _____ Best # to reach you: _____

List any other people living in the home, their age, and relationship to your child:

Who has custody? _____

Prenatal and Birth History

Were there any previous pregnancies? ☐ Yes ☐ No
During this pregnancy, did the child's mother experience any unusual illness, condition or accident (e.g. German measles, Rh/blood incompatibility, toxemia, maternal diabetes)? ☐ Yes ☐ No
If yes, please provide pertinent information: _____

Patient Label

Was there any drug or alcohol use during pregnancy? ☐ Yes ☐ No If yes, please describe: _____

_____

Length of Pregnancy: _____ Type of Delivery: ☐ Cesarean ☐ Vaginal
Child's Birth Weight: _____ Hospital Stay following birth: _____
Was your infant in the Intensive Care Nursery? ☐ Yes ☐ No For how long? _____

Were any of the following present after birth?

Seizure Activity	☐ Yes	☐ No
Feeding difficulties	☐ Yes	☐ No
Difficulty sucking or swallowing	☐ Yes	☐ No
Difficulty regaining birth weight	☐ Yes	☐ No
Need for oxygen	☐ Yes	☐ No

Medical History

Primary Physician: _____
Specialty Physicians: _____
General health of your child? ☐ Excellent ☐ Average ☐ Poor
Allergies? ☐ Yes ☐ No If yes, please list: _____
LATEX ALLERGY ☐ Yes ☐ No
Do you have any concerns about your child's vision or hearing? ☐ Yes ☐ No If yes, please explain: _____

_____

Respiratory Difficulties? ☐ Yes ☐ No If yes, please explain: _____

_____

List any medical condition your child has been diagnosed with and age at diagnosis (e.g. hearing or visual impairments, cerebral palsy, heart condition, epilepsy, attention deficit disorder, autism, etc.): _____

_____

_____

List any childhood illnesses or diseases your child has had, the age at which they occurred, and treatment provided (e.g., ear infections, age 6 months to 2 years, antibiotics and tubes on 2/98): _____

_____

Has your child been hospitalized since birth? ☐ Yes ☐ No
If yes: please provide dates and reason: _____

_____

List any medications your child is taking at this time and why (include botox injections): _____

_____

_____

Is there a family history of any of the following?

Genetic Disorder	☐ Yes	☐ No
Chromosome Deficiency	☐ Yes	☐ No
Learning Disabilities	☐ Yes	☐ No
Speech and Language delays	☐ Yes	☐ No

Patient Label

Previous Evaluations and Therapy

Has your child had any of the following evaluations?

			Treatment Recommended?
Speech/Language Evaluation	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Psychological Evaluation	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Hearing Evaluation	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Vision Evaluation	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Neurological Evaluation	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Feeding/Swallowing	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No

If yes to any, please provide information regarding the results of evaluation: _____

_____

Has your child previously received any of the following therapy?

			Ongoing?
Speech/Language Therapy	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No	Where/When? _____	☐ Yes ☐ No

What was the result of therapy: _____

_____

Developmental Motor Milestones/History

Did/does your child tolerate tummy time? ☐ Yes ☐ No

At what age did your child do the following:

First hold their head alone? _____

Roll: Tummy to back? _____ Back to tummy? _____

Sit alone without support? _____

Crawl? _____ How? (hands and knees or on tummy) _____

Pull self up to standing position? _____

Walk unaided? _____

Become completely toilet trained? _____

Does your child have any physical limitations at this time? _____

_____

Current Equipment (include braces, walkers, wheelchairs, scooters, lifts, etc.): _____

_____

_____

Social, Behavioral, and Educational History

Is your child:

Cared for by a baby-sitter if you are employed outside the home? ☐ Yes ☐ No

Attending daycare? ☐ Yes ☐ No If yes, please state where? _____

Involved with Early Access or your local Area Educational Agency? ☐ Yes ☐ No

Attending an Early Education Program (age 3-5) at school? ☐ Yes ☐ No

Attending a Preschool or School? ☐ Yes ☐ No If yes, where? _____

What grade? _____

Patient Label

If your child is school aged has he/she:

Exhibited any difficulty with schoolwork? ☐ Yes ☐ No If yes, please explain: _____

Been enrolled in any special education classes? ☐ Yes ☐ No If yes, please explain: _____

Received any resource help in particular areas? ☐ Yes ☐ No If yes, please explain: _____

Repeated any grades? ☐ Yes ☐ No

Participated in any community resources? ☐ Yes ☐ No If yes, please list: _____

Does your child have any difficulty with eating/drinking? ☐ Yes ☐ No If yes, please explain: _____

How does your child take liquids? (nursing, bottle, sippy cup, open cup, straw) _____

Is your child eating solid foods? ☐ Yes ☐ No

Is there a history of a feeding tube? (NG-tube, G-tube) ☐ Yes ☐ No If yes, please explain: _____

Does your child sleep well? ☐ Yes ☐ No If no, please explain: _____

If your child is under the age of 2 please complete the following:

What position does your child usually sleep in? _____

Does your child sleep in a crib? ☐ Yes ☐ No If no, please explain: _____

How well does your child play:

Alone? _____

With other children? _____

What are your child's favorite toys and/or entertainment? _____

How does your child communicate? (e.g., speech, sign language, communication device, other) _____

Does your child communicate clearly? ☐ Yes ☐ No If no, please explain: _____

Additional Information

Please add any additional information that might be helpful in the evaluation of your child: _____

Select the number on the scale of 1 through 10 (1 being the least and 10 being the most), how would you rate your level of concern in relationship to your child's difficulties at this time?

(Least Concerned) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Most Concerned)

Person completing form: _____

Relationship to child: _____

Signed: _____ Today's Date: _____

Patient Label