siskin children's institute
education • outreach • health care • research

center for DEVELOPMENTAL PEDIATRICS
An academic pediatric practice affiliated with the University of Tennessee College of Medicine Chattanooga

Therapy Case History

Patient and Family Information

Child's Name: _____

Birth date: _____

☐ Male ☐ Female

Primary Caregiver(s) Name: _____

Relationship to child? _____

Daytime Phone: _____

During the therapy evaluation, the therapist will meet with you and your child to discuss concerns and complete appropriate testing. To help your therapist better prepare for the evaluation, please answer the following questions:

Primary language spoken in the home:

☐ English
☐ Spanish
☐ Other _____

What is your main reason for coming for today's therapy evaluation?

_____
_____

What has your doctor told you about your child?

_____
_____

Does your child speak to communicate? If yes please check which best applies:

☐ simple words
☐ repeats words
☐ simple phrases
☐ complete sentences

If no, what does your child do to communicate?

☐ Rarely tries to communicate
☐ cries/tantrums
☐ uses facial expressions/body language
☐ communication device
☐ other

Can your child follow verbal directions? If yes check which best applies:

☐ Simple (such as "get the ball")
☐ Moderate ("go get the ball from the next room and bring it back to me")
☐ Complex ("after you finish your homework, put away the dishes")

Will your child copy an action after a visual demonstration, such as copy a pattern with blocks, walk on a line, or match a pattern?

☐ No
☐ Usually
☐ Always (if physically able to complete)

Is your child likely to be very scared/anxious about coming to evaluation?

☐ Yes
☐ No

If yes, is there any way you have found to help calm/soothe your child?

_____

Gross Motor Skills are skills that use large muscles and generally affect whole body, such as crawling, standing, walking, and running. Do you currently have concerns about his/her gross motor skills?

☐ Yes
☐ No

If yes, please explain:

_____
_____

Fine motor skills are skills that use the small muscles of the hands for many play, school and self-care tasks, such as holding a crayon, stringing beads, cutting and fastening buttons. Do you currently have concerns about your child's fine motor skills?

☐ Yes
☐ No

If yes, please explain:

_____
_____

Communication skills include being able to listen to others (receptive communication) speak to others (expressive communication). Do you have current concerns about your child's communication skills?

☐ Yes
☐ No

If yes, please explain.

_____
_____

Sensory processing is the ability to be able to use information from the body (touch, balance) and outside world (touch, sound, taste, smell, vision) to act appropriately on that information. Examples include being able to hear a car horn and move out of the way, or tolerating being able to wash hands. Some children respond very strongly to sensory information or seem to not notice this sensory information. Do you have any concerns about your child's sensory processing skills?

☐ Yes
☐ No
If yes, please explain.
_____
_____

Birth History

Mother's health during pregnancy:

☐ Good ☐ Poor
☐ Fair
Please describe: _____

History of alcohol and/or drug abuse during pregnancy:

☐ Yes
☐ No
Please describe: _____

Length of Pregnancy: _____

Child's Birth Weight: _____

Problems during or after delivery:
_____

Did the child go home with his/her mother from the hospital?

☐ Yes
☐ No
If no, please describe why and how long:
_____

Medical History

Please list any current or previous diagnoses:
_____

Medications your child takes regularly:
_____

Allergies to food or medication:
_____

Has your child completed a hearing test?
☐ No ☐ Concerns/Failed
☐ Passed

Has your child ever been hospitalized, had a serious accident, or had an operation:

☐ Yes
☐ No
If yes, please describe:
_____

Additional medical information:
_____
_____

Developmental History

Has your child been delayed in any of the following milestones? (Please check if delayed)

☐ Sitting up
☐ Rolling over
☐ Crawling
☐ Walking
☐ Babbling
☐ Saying single words
☐ Saying multiple words

Toileting:

☐ Wears diapers
☐ In process of toilet training
☐ Needs help in bathroom
☐ Independent

Does your child:

☐ Drink from bottle
☐ Drink from sippy cup
☐ Drink from cup
☐ Eat soft foods
☐ Eat hard/crunchy foods
☐ Eats variety of textures
☐ Tube fed

Does your child currently have problems with (check all that apply):

☐ Chewing
☐ Using forks/spoon
☐ Limited food preferences
☐ Poor appetite
☐ Sitting for completion of meal
☐ Swallowing

Does your child eat a variety of foods?
☐ Yes
☐ No
If no, please list preferred foods:
_____

School History

Is your child in a school/daycare?

☐ Yes
☐ No

Name of school/daycare:
_____

Grade: _____

Does your child have an IEP?
☐ Yes
☐ No

What (if any) services are your child receiving through school?

☐ Speech Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Other

Therapy History

Has he/she received early intervention (TEIS/BCW) services in the past/been tested?

☐ Yes
☐ No

Has he/she previously received:

☐ Speech therapy
☐ Occupational therapy
☐ Physical therapy

What were you told about his/her therapy?
_____

Social History:

Please describe your child's social skills:

☐ Prefers to play alone
☐ Plays well with other children his/her age
☐ Excessive shyness/clinging to caregiver
☐ Limited initiation of social contact
☐ Social anxiety
☐ Difficulty maintaining social interaction
☐ Peer conflict
☐ Difficulty showing emotion

What are his/her favorite toys, games or play activities?

_____

_____

Additional comments/concerns regarding your child:

_____

_____

_____