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Home Health Services – Child Case History Form

Child Information **Date**

Name / Gender	Name		Gender ¨ M ¨ F
Date of Birth / Age / School	Date of Birth	Age	Grade / School
Home Address	Street		Apartment
	City	State	Zip Code
Emergency Contact	Name		Phone

Parent / Guardian Information

Parent / Guardian One	Name		Gender ☐ M ☐ F
Phone Number	Home	Work	Cell
Employment	Employer Name		Occupation
Parent / Guardian Two	Name		Gender ☐ M ☐ F
Phone Number	Home	Work	Cell
Employment	Employer Name		Occupation
E-mail Address	Parent / Guardian One		Parent / Guardian Two

Who referred you to Kid Adventures Pediatric Therapy PLLC?

Name	
Relationship to Child	
Reason for Referral	
Previous services by our company?	

Other Primary Caregivers

Caregiver (other than parent / guardian)		

Please List all People Residing in your Home

Name	Relationship	Age

Significant Family Medical History

[e.g., Speech-Language, Hearing, Sensory/Motor or Learning Disability; impaired attention; anxiety / depression; other disease or condition]

Name	Relationship	Diagnosis

Birth and Developmental History

Birth and Infancy

Pregnancy	YES	NO	N/A	Additional Information
Was mother's health during pregnancy good to excellent?				
Were medications taken during pregnancy?				What / when:
Was baby born at term (due date) or within two weeks before / after the due date?				
What was baby's birth weight?				
Was your child adopted?				Country of Origin:
If adopted, what was child's age at adoption?				
If adopted, is there any known history that could be related to the current problem?				
Labor and Delivery				
Were labor and delivery normal?				
Was labor induced?				
Was birth by Caesarian Section?				
Was there evidence of injury or poor health at birth?				
What were baby's APGAR scores?				
Other:				
Infancy				
Were there any feeding problems?				
Did baby exhibit average activity level?				
During the first several months of life, was baby's health good?				
Other:				
Other:				

General Development

Developmental Milestones			N/A	Additional Information
When was child able to sit unassisted?	Age:			
When did crawling emerge?	Age:			
When did walking emerge?	Age:			
When did child begin to babble?	Age:			
When did child produce first words?	Age:			
When did child begin combining words?	Age:			
Gross and Fine Motor	**YES**	**NO**	**N/A**	**Additional Information**
Is there a history of problems with gross motor skills (walking, running, climbing)?				
Are there currently any problems with gross motor skills?				
Is there a history of problems with fine motor skills (e.g., picking up objects, dressing)				
Are there currently any problems with fine motor skills?				
Which hand does child use most often?				❑ Left ❑ Right ❑ Uses both hands equally
Communication	**YES**	**NO**	**N/A**	**Additional Information**
Did speech and language development seem to progress normally, and then stop or regress?				
Does child seem to understand what is said?				
Does child follow spoken directions?				❑ 1-step ❑ 2-step ❑ 3+ steps
Does child talk?				
Does child produce vocalizations that sound like the language of the home, but are unintelligible (e.g., jargon-like)?				
Which of the following does your child use most often?				❑ Sounds ❑ Syllables ❑ Gestures ❑ Sounds + gestures ❑ Single words ❑ Series of single words (pauses between words) ❑ Single words + short phrases ❑ Complete / grammatically incorrect sentences ❑ Complete / grammatically CORRECT sentences ❑ Retells stories / experiences others understand
Does your child often hesitate when speaking and/ or repeat sounds / words /				
Child's speech / pronunciation is				❑ Understood by everyone ❑ Understood by family / caregivers ❑ Poorly understood ❑ Unintelligible ❑ Absent
Child's speech rate is				❑ Too Fast ❑ Too Slow ❑ Average
Child's volume is				❑ Too Soft ❑ Too Loud ❑ Average
Child's voice quality is				❑ Hoarse ❑ Nasal ❑ Average ❑ "Stuffed" – Like during a cold
Other:				
Hearing	**YES**	**NO**	**N/A**	**Additional Information**
Does child have a history of hearing loss?				
Does child wear a hearing aid?				
Does child appear to have difficulty hearing?				
Is child consistent in response to sounds and voices?				HA Type:
Please provide information regarding child's most recent hearing test.	Date:			Results:

Medical History	YES	NO	N/A	Additional Information
Please list all diagnoses:				
Has child ever had a fever of 104° or more?				
Is child currently under treatment for any medical condition?				
Are there any problems with vision?				
Has child had vision screened or tested?				Results:
Does child wear corrective lenses for vision?				
Is development of teeth normal?				
Does child sleep well?				
Does child have a good appetite?				
Is child on a special diet?				

Medications **Please complete this section if child takes prescription or over-the-counter medication regularly.**	Name	Dose	How Often	Reason Taken
Medication:				
Medication:				
Medication:				
Medication:				
Medication:				

Diseases or Conditions **Please provide information regarding history of diseases.**	Age	Describe Treatment and / or Complications
Allergies (i.e., food, insect bites, latex, pollen, medication, etc.)		
Chicken Pox		
Chronic Colds		
Ear Infections		
Lead Poisoning		
Measles		
Mumps		
Spasms, convulsions, or seizures		
Tonsillitis		
Other:		

Injuries and / or Surgeries **Please provide information regarding any injury, surgery, or hospitalization.**	Age	Describe Treatment and / or Complications

Previous Evaluations	YES	NO	Date	Agency/Person
Educational / Psychological Testing				
Hearing / Audiology Evaluation				
Occupational Therapy Evaluation				
Physical Therapy Evaluation				
Speech Language Evaluation				

Previous Therapy	YES	NO	Date	Agency/Person
Counseling				
Occupational Therapy				

Physical Therapy				
Speech Language Therapy				
Tutoring				

Other Information related to Medical and / or Developmental History

Other information you would like us to know about your child's medical and / or developmental history:

Social and Emotional History

Behaviors	**YES**	**NO**	**N/A**	**Additional Information**
Is child more interested in objects than people?				
Does child demonstrate self-stimulating behaviors?				❑ Rocking ❑ Arm Flapping ❑ Hand movement ❑ Other:
Does child demonstrate head-banging?				
Does child "give up" easily?				
Does child exhibit ritualistic or compulsive behaviors?				
Does child engage in behaviors that are dangerous to self or others?				
Other:				

If child exhibits or has exhibited the following behaviors, please indicate age of occurrence and describe attempts made to alter the behaviors.

Behavior	**Age (from – to)**	**Attempt to Alter Behavior**
Bedwetting		
Depression		
Difficulty separating from parents		
Difficulty sitting still		
Frequent headaches / stomach aches		
Inability to stay with one activity until completion		
Negative self-esteem		
Nervousness / anxiety		
Noncompliant / defiant		
Physically strikes out at others		
Shyness		
Sleeplessness		
Strong fears – nightmares		
Temper tantrums		
Thumb sucking		

Please answer the following questions regarding your child's behavior.			
What types of activities or toys does your child prefer?	Please describe:		
Does your child play with other same-age peers?	YES	NO	Please describe:

Are you ever concerned that your child doesn't play well with other children?	YES	NO	Please describe:
Do you feel that your approach to discipline is effective?	YES	NO	Please describe:

Other Information related to Social and Emotional History

Other information you would like us to know about your child's social and emotional history:

Language History

Child's Primary Language	
Other Language Exposure	
Age at which other Language(s) Introduced	
Where (e.g., Home, Daycare, or School)?	
Who Speaks other Language?	
Child is able to	❑ Speak _____ ❑ Understand _____ ❑ Write _____ ❑ Speak _____ ❑ Understand _____ ❑ Write _____

Educational History

Name of public school district where child lives			
Previous schools attended			
Current school			
Previous school(s)			
Highest grade completed	1 2 3 4 5 6 7 8 9 10 11 12		Current Grade:
Has child ever repeated a grade?	YES	NO	Please describe, including grade(s) repeated
Are there any current concerns regarding school performance?	YES	NO	Please describe
Does child receive any special services at school?	YES	NO	If so, what services are received?

Additional Information

Other information you would like us to know about your child:		
Primary Care Physician		
Name	Address	Phone

Person Completing this Form	
Relationship to the Child	

Signature: _____

Date: _____