2498 Dayton-Xenia Rd.
Beavercreek, Ohio 45434
Phone: 937-427-1919
Fax: 937-427-1949

Therapy Connections, LLC

Case History Form

Please fill out this form as completely as you can. Your therapist may ask you additional questions to clarify or expand information.

Date: ______________________

I. Patient Information

Client's Name: ____Date of Birth____/_____/_____
Parents Name: ____
Address:____
Street Address City State Zip
Telephone Number: (____)____________________Cell Phone Number:(____)___________________________
Physician: ________________________________Referred by: ____
Reason for Referral: ____
Diagnosis, if any: ____
Allergies: ____
Medical Precautions: ____
Dietary Restrictions:____
Medications: ____
What are your main concerns with your child: ____
____
____
What does your child find enjoyable:____

II. Prenatal and Birth History

Child was born: full-term____ premature____ how many weeks___________________
Delivery: vaginal _____ forceps _____ vacuum _____C-section____
Did you have any complications____
____
Was your child placed in the Intensive Care Unit?______ If so, how long?________________________________
Please describe any other prenatal medical problems or complications at birth:_____________________________
____

III. Developmental Milestones – (mark approximate month)

Rolled over_________ Babbled___________ Said first word_____________ Walked alone____________
Crawled___________ Sat alone__________ Pulled to a stand___________ Used spoon_____________
Drank from a cup_____ Stood alone_________ Toilet trained______________ Dressed self ____________
Current physical limitations:____
____
Comments:____
____

Discover Abilities … Achieve Results… Experience Success.

IV. Medical History (please include dates)

Hospitalizations: No _____ Yes_____ If yes, please describe_______________________________________
____
Surgical Producures:____
____
Previous psychological evaluation: No ____ Yes_____ If yes, please describe___________________________
____
Special equipment your child uses: Splints____ Braces____ Adaptive utensils_____ Other________________
Please check all that apply to your child:
___Hearing aids ___Hearing difficulty ___Ear Tubes ___Chronic ear infections
___Vision difficulty ___Vision testing ___Glasses ___G-tube ___C-Line
Please list any information regarding ear infections, enlarged tonsils or adenoids, mouth breathing _________
____
Additional Comments: ____
____

V. School History/ Previous Therapy

School/Educational program currently attending and grade:____
Special services received in school (include teacher/therapist if known):
OT ______ PT ______ Speech ______ Special Education ______ Behavior Intervention ________
Other special service ____ Please list:____
Does your child's teacher have concerns with your child's development in any of the following areas?
Motor skills________ Social abilities _______ Self-help skills________ Learning abilities __________
School history including preschool and early intervention____
____
Previous Therapy ____
____
Additional Comments:____
____

VI. Behavior

Please check any of the following that apply to your child:

___ Cries often
___ Dislikes hair brushing
___ Clumsy
___ Dislikes tooth brushing
___ Anxious
___ Rocks self
___ Mouths objects
___ Grinds teeth
___ Seems to be "on the go"
___ Poor attention span
___ Weak muscles
___ Sensitive to light
___ Picky eater
___ Trouble with directions
___ Sensitive to sound
___ Avoids touch from others
___ Poor attention span
___ Trouble with transition
___ Crave jumping/crash play
___ Trouble attending to task
___ Dislikes playground

VII. Social/Emotional Development

Does your child interact well with others ____Yes ____ No
Does your child have any trouble making friends? ____ Yes ____ No
Does your child have difficulty calming when upset ___Yes ____ No
Fears, Coping behaviors: ____
____
Additional comments: ____

VIII. Speech History
Tell about babbling/cooing behavior - did it seem normal? Little or a lot of sound play as a baby:
____
____
First words, was it before 18 months _____ or after 18 months __________
When did your child begin to combine words into simple phrases or sentences: _________________________
Please give examples of common sentences your child says:____
____
Is your child easy to understand by family? Do other's (friends, playmates) understand his/her speech:
____
What percentage of your child's speech do you understand? ______________ strangers?________________
Any concerns with stuttering?____
Any history of cleft lip/palate or dental anomalies?____

IX. Feeding History
Early feeding: bottle/breast/both (until what age)____
Any difficulties with early feeding ____
Any problems with (describe below):

___Gagging ___Choking ___Reflux ___Excessive Drooling
___Food Stuffing ___Pocketing/holding ___Puree foods ___ Solid Foods
___Cup Drinking ___Straw Drinking ___Self-feeding ___Picky Eater

Please describe marked items: ____
____
Any nutritional concerns? Is your child eating a good variety of foods? _________________________________
____
Food Preferences/Dislikes (Taste, Texture)____
____
Additional comments: ____
____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

________________________________ ___________________
Signature Date