GENERAL CASE HISTORY

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| Patient’s Name: | | | Date: |
| Date of Birth: | Age: | | Grade Level: |
| Name of School Currently Attending: | | | |
| Parent/Guardian Names: | | | |
| Phone Numbers: (home) | | (cell) | |
| Referring Physician: | | Pediatrician, if different than referring physician: | |

REASON FOR EVALUATION (must be completed):

**BIRTH HISTORY**

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| --- | --- | --- | --- |
| Maternal illnesses/complications during pregnancy: | | | |
| Mother’s age at birth: | | Gestational weeks at birth: | |
| Type of Delivery: Vaginal or Caesarian | | Reason for Caesarian: | |
| Complications during/after delivery (forceps, vacuum, breech, jaundice, infection, breathing problems, other): | | | |
| Time in Labor: | Birth Weight: | | APGAR score: |
| Did the child require: Ventilator (Length of time \_\_\_\_\_\_\_\_\_) or Feeding Tube (Length of time\_\_\_\_\_\_\_\_\_) | | | |
| How long was the child in the hospital after birth? | | | |
| Other information related to birth history? | | | |

GENERAL CASE HISTORY (CONT’D)

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| Medical Diagnosis(es):  (Anxiety, Asperger’s, Autism, Scoliosis, Learning Disorder, Rett Syndrome, Down’s Syndrome, Developmental Disorder, Sensory Disorder, Feeding Disorder, etc.) |

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| Allergies:  (Medication allergies, Latex, Food, etc.) |
| Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Head Circumference: \_\_\_\_\_ |

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| Has the child had an EYE EXAM? Y/N  Date: Results: |
| Has the child has a HEARING TEST? Y/N  Date: Results: |
| Has the child had IMMUNIZATIONS? Y/N  Yes, some: Yes, up to date: Y/N |
| Has the child had any REACTIONS TO IMMUNIZATIONS? Y/N  Explain: |
| Does the child have frequent EAR INFECTIONS? Y/N Has PE Tubes? Y/N  Date of Tubes placement: |
| Does the child have frequent COLDS? Y/N  Number per year: |
| Has the child ever had a high fever (>102 degrees F)? Y/N  Explain: |

Please list any Hospitalizations, Major Injuries/Accidents, Surgeries and/or Major Illnesses, DATE AND EXPLANATION:

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| List any other Specialist/Physician (Orthopedist, Neurologist, etc.) the patient sees (Name and Specialty): |

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| List any special services the patient receives (Babies Can’t Wait, Special Education, Georgia Cyber Academy, etc.): |

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| List any current PRESCRIBED and OVER THE COUNTER medication the patient is taking: |

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| Other information related to Medical History: |

**PHYSICAL DEVELOPMENT**

Does the patient: Age Achieved:

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| --- | --- |
| Sit Unsupported Y/N |  |
| Crawl Y/N |  |
| Walk Y/N |  |
| Feed Self with Spoon Y/N |  |
| Dress Self Y/N |  |
| Control his/her Bladder Y/N |  |
| Bathe Self Y/N |  |

SPEECH/LANGUAGE DEVELOPMENT

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| Language (s) Spoken in home: English Spanish Other: |
| How much of the child’s speech is understood by:  Family: \_\_\_\_\_\_\_\_\_\_% Unfamiliar people: \_\_\_\_\_\_\_\_\_\_\_% |
| Description of Speech Problems: |
| Has your child ever been evaluated for speech? YES NO  If yes, please specify the date and the provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please List The Age The Child First Performed The Following:

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| --- | --- | --- |
| First Word | Age Achieved: | Does not perform |
| Two Word Combinations | Age Achieved: | Does not perform |
| Sentences | Age Achieved: | Does not perform |
| Conversations | Age Achieved: | Does not perform |
| Counting 1-10 | Age Achieved: | Does not perform |
| Recognize 5 colors | Age Achieved: | Does not perform |
| Follow 2-step directions | Age Achieved: | Does not perform |
| Initiate conversation with others | Age Achieved: | Does not perform |

**FEEDING DEVELOPMENT**

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| Is/Was the patient breastfed? Y/N How Long: |
| If currently breastfeeding: How long? Schedule? |
| Did/Does the patient take formula? Y/N Type: Amount: |
| If currently taking formula: Amount? Schedule? |
| Did the patient experience Colic? Y/N |
| Did/Does the patient take a pacifier? Y/N What style/brand(MAM, Dollarstore, NUK, etc.): |
| The patient currently drinks from a (choose one): Bottle Sippy Cup Regular Cup Straw Other |
| Does the patient eat jar foods? Y/N Any issues transitioning to jar food? Y/N  Stage I Stage II Stage III Graduates  Table Foods: |
| Does the patient drool excessively? Y/N |
| Does the patient have preferred temperatures/textures? Y/N Warm Cold Hot Room Temp  Explain: |

**BEHAVIOR**

Does the patient: Will the patient:

|  |  |
| --- | --- |
| Play with other children? Y/N | Swing? Y/N |
| Have close friends? Y/N | Slide? Y/N |
| Have preferred toys? Y/N | Play in a sandbox? Y/N |
| Play outside? Y/N | Walk barefoot in grass? Y/N |

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| --- | --- |
| Describe any behavior that is problematic for the parent/guardian: | |
| Age first noticed problem: | Severity: Mild Moderate Severe |

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| Describe any strong reactions the patient might have to specific fears/ situations: |

**FAMILY/SOCIAL HISTORY**

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| Are the patient’s parents together? Y/N Explain: |
| How is (are) the legal guardian(s) related to the child: |
| Is the child adopted? Y/N Age of Adoption: |
| Mother’s occupation:  Name of business: |
| Father’s occupation:  Name of business: |
| Name of daytime caregiver/daycare: |
| Siblings/Ages: |
| Others living in the home: |
| Other family members with speech/language problems: |
| Other family members with physical/motor developmental problems: |

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_