CHILD CASE HISTORY FORM

Date: _____ 20___

Child's Name: _____ Age: _____

Birth date: _____ Sex: _____

Mother's Name: _____ Occupation: _____

Address: _____

Zip Code: _____ Home #: _____ Work #: _____

E-mail: _____ Cell #: _____

Father's Name: _____ Occupation: _____

Address: _____

Zip Code: _____ Home #: _____ Work #: _____

E-mail: _____ Cell #: _____

Physician: _____ Phone: _____

Address: _____ Referred By: _____

INSURANCE INFORMATION

Person responsible for payment: _____

Relationship to child: _____ Employer: _____

Social Security #: _____ - ____ - _____ Date of Birth: _____

Phone #: _____

Primary Insurance: _____ ID or Policy #: _____

Other Insurance: _____ ID or Policy #: _____

DEVELOPMENTAL HISTORY

1. Pre-natal Health of Mother

   a. Length of Pregnancy: _____ Time in Labor: _____

      Birth weight: _____ lbs. _____ oz.

   b. Accidents: _____ Medications: _____

      Illnesses: _____

      History of Miscarriages: Yes / No

   c. Difficulties at Time of Birth: _____

2. Child's Record:

a. Sat alone: _____ months
b. Walked alone: _____ months
c. Toilet trained: _____ months
d. Physical development:
slow / fast / normal
e. Coordination:
good / average / poor
f. Feeding difficulties: Yes / No
g. Vision difficulties: Yes / No
h. Serious illnesses: Yes / No
i. Serious accidents: Yes / No
j. History of high fever: Yes / No
k. History of seizures: Yes / No
l. Presently receiving medication:
Yes / No Type: _____
m. Usually breaths with mouth open:
Yes / No
n. Frequently experience: colds?
earaches? sore throats?
o. Basic language used at home:
_____

FAMILY

Other Children:

Name	Age	Sex	School

COMMUNICATIVE BEHAVIOR

Do you think your child has a speech problem? _____

Is the child able to make his/her needs made known verbally? Yes / No

Is the child responsive to sounds or voices? Yes / No

Can the child be understood by… Parents Yes / No
Other children Yes / No
Strangers Yes / No

Does the child easily interact with others? Yes / No

Does any member of the family have a speech or hearing problem? Yes / No

Has the child been given a speech (Yes / No) or hearing (Yes / No) evaluation?

If yes: when? _____

when? _____

SOCIAL AND ADAPTIVE BEHAVIOR

Does the child dress self completely? Yes / No

Does the child comb hair without help? Yes / No With help? Yes / No

Does the child brush teeth without help? Yes / No With help? Yes / No

Does the child bathe without help? Yes / No With help? Yes / No

Does the child feed self independently? Yes / No

If no: Does the child use fork or spoon? Yes / No

Does the child drink from cup or glass without spilling? Yes / No

Can child dial a telephone without help? Yes / No

Does the child know own telephone number? Yes / No

Does the child play outdoors without supervision? Yes / No

What does your child do that you consider outstanding? _____

_____

What concerns, if any, do you have about your child?

a. _____

b. _____

c. _____

_____ _____

Signature Relationship to Child

Date: _____