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Case History & Background Information

Today's Date:_____

Part I: Child and Family History

Child's Name:_____

Date of Birth:_____ Age:_____ Gender: M or F

Delivery: Vaginal C-section Weeks of gestation when the child was born _____

Were there any complications with pregnancy or delivery? Yes No. If yes, please explain

_____

_____

_____

Current diagnosis (all)	age at time of diagnosis
_____	_____
_____	_____
_____	_____

What school does your child attend _____

Grade _____ Is there an IEP in place: yes no

If yes, what was the date of last IEP meeting_____

*please provide us with a copy of the IEP for the last 2 years.

What type of classroom is your child in at school:

mainstream, self-contained, combination

Describe (if any) the special support your child gets at school:

_____

Child's home address:

Language(s) spoken in the home:

Child presently lives with:

Child's primary caregiver(s):

Parent's Full Name:

Date of Birth:

Occupation:

E-mail address:

Business Phone:

Cell phone:

Significant Medical history:

Parent's Full Name:

Date of Birth:

Occupation:

E-mail address:

Business phone:

Cell phone:

Significant Medical history:

Developmental History

At approximately what age did your child do the following?

	Early	Average	Late
Sit			
Crawl			
Walk			
Babble			
Use single words			
Combine 2 words			
Use phrases			
Use sentences			
Ask questions			
Engage in conversation			

Siblings: Name Date of Birth School and grade

1. _____
2. _____
3. _____
4. _____
5. _____

Is there any family history of difficulties similar to those your child is experiencing? Is there any family history of language, learning or developmental delays, mental illness, autism or other pervasive developmental problems? If so, please describe._____

_____

_____

_____

_____

Medications, list all separately:

Name of medication	Dosage Frequency taken	For what diagnosis	Age when medication started	Prescribing doctor
EXAMPLE: **Vyvance**	**10 mg once a day**	**ADHD**	**4 years**	**Dr. Who**

Current Treatment or Intervention:
☐Speech Therapy ☐Occupational Therapy ☐Physical Therapy ☐Behavior Intervention ☐ psychotherapy

List special things your child likes: sugar cookies, Disney movies, toys, etc

Edible	tangible	activity	social	Other

List Food Allergies_____

List Insect Allergies _____

List Drug Allergies _____

If your child's medical history includes any of the following, please report the child's age at occurrence, number of occurrences and any other pertinent information.

Accidents:_____

Allergies:_____

Asthma:_____

Childhood diseases:_____

Colds (persistent):_____

Colic:_____

Ear infections:_____

Eye infections:_____

High fever (persistent):_____

Hospitalizations:_____

Operations:_____

Seizures:_____

Sinusitis:_____

Throat infections:_____

Tonsillitis:_____

Other:_____

_____

Present medical conditions your child is being treated for:

_____

History and Synopsis of concerns:

Describe **what your child spends most of his/her time doing** during the day when with you_____

_____

_____

Describe **what you spend most of your time doing** during the day when with your child_____

_____

_____

Does your child play alone? _____

Has your child had a recent hearing test?_____ Results?_____

Academics: Does your child:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Read					
Identify letters					
Identify numbers					
Cut					
Sit for a story					
Color					
Write Color					
Hold a crayon					
Hold a pencil					
Sit in a chair					
Look when name is called					

Activities of Daily Living:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Brush teeth					
Wipe after toileting					
Wash in the bath					
Pick out clothes					
Use a fork					
Use a spoon					
Drink from open cup					
Drink from sippy cup					
Dress					
Undress					
Tie shoes					

Additional concerns related to daily living skills

_____

_____

_____

_____

Sensory issues your child currently

Describe any Sensory seeking

behaviors_____

_____

Describe any sensory defensiveness

behaviors_____

_____

Self Injurious Behaviors: Does your child self-injure? Yes no

Ex. Head bang, cut, self-bite, skin pick

Describe_____

_____

_____

Safety skill deficits your child

has_____

_____

_____

_____

_____

Does your child feel pain? yes no How do you know?

_____

_____

_____

_____

Transitions: Does your child transition cooperatively from preferred activities to non-preferred activities?

_____

_____

_____

Feeding and Nutrition:

Was your child breastfed or bottle fed?_____

When was your child weaned?_____

Was your child weaned to bottles, cups, or both?_____

Does your child currently drink from bottles, sippy cups, straws, or open cups?

_____

Does your child use utensils independently?_____

Was feeding your child ever difficult? If so, please explain._____

_____

_____

Does your child have any difficulty sucking, chewing, or swallowing? Please describe.

_____

_____

Is your child a picky or fussy eater?_____

Does your child eat a variety of foods? Please check all that apply.

soft_____ chewy_____ crunchy_____

sticky_____ pureed_____ hot_____

cold_____ meats_____ breads_____

fruits_____ vegetables_____ sour_____

sweet_____ spicy_____ dairy_____

If your child does not eat a variety of foods, please describe current diet._____

_____

_____

Fruit	Vegetables	Lean meats	Dairy	Processed meats	Complex carbohydrates	Snack foods	Fast foods	Home cooked Fried foods	drinks	other
.										

Narrow or Limited Interests: Does your child have limited interest in things (only plays with one toy, watches same movie, eats only certain food)_____
_____
_____
_____

Stereotypical Behaviors: Does your child engage in repetitive behaviors such as spinning, hand flapping, echoing things heard, staring at lights, flicking fingers in front of eyes_____
_____
_____

Attending Skills: how long will your child sit and work on one activity_____. What does your child do if requested to complete a nonpreferred activity
_____
_____

Play Skills:

Describe your child's play skills

_____.

What is played with_____. Are toys played with as their intended purpose yes no. Who does your child play with: adults children alone. What does your child's interaction look like when playing with other children_____

_____

Communication Development

When you talk to your child, how much do you feel is understood:

a few words_____ many words and phrases_____

simple directions and questions only_____

almost everything I say_____

How does your child communicate wants and needs? Check all that apply.

cries_____points_____signs_____

pulls toward object_____gestures_____vocalizes sounds_____

uses single words_____uses many words, but only one at a time_____

uses phrases_____uses long sentences_____

Does your child answer when you call?_____

Does your child answer yes/no and wh- questions?_____

Does your child ask for help?_____

Does your child talk about what he/she is doing?_____

What does your child like to talk about?_____

_____

_____

_____

Does your child get stuck on a favorite topic or insist on only talking about what he or she wants to talk about: ie. Disney, dogs, sharks,

What percentage of your child's speech do you understand?_____

Can people outside the family understand your child's speech?_____

Does your child stutter or stammer?_____

Did you ever notice a change in your child's behavior, language, or social skills? If so, please describe the change and when it occurred._____

What are your child's favorite toys and/or play activities?_____

Describe how he/she plays with them?_____

Does your child have any sensory difficulties (tactile, visual, auditory etc.)? If yes, please describe._____

How does your child respond to changes in the environment or routine?_____

How does your child transition from one activity to the next?_____

Does your child prefer to be alone: yes no

Does your child show a preference to be with: adults children animals

Does your child insist on routines: yes no

How does your child gain attention?_____

Who does your child enjoy playing with?_____

_____

Describe how your child interacts with adults and peers._____

_____

_____

_____

Does your child engage in behaviors when things change, are out of order or otherwise different: yes no

Please describe such behaviors:

_____

_____

Present Concerns

Please describe your concerns regarding your child's speech, behaviors, feeding, play, following directions and/or social development._____

_____

_____

_____

_____

When did you first notice the difficulty?_____

_____

Has the problem changed since you first noticed?_____

_____

Is your child aware of the problem?_____

Does your child's communication difficulty cause frustration?_____

_____

What have you done to help your child with these difficulties?_____

_____

Has your child ever been evaluated for therapeutic services? If yes, when and what were the recommended services?_____

Does your child currently attend school or group activities?_____

How do his/her peers and teachers react to the communication difficulty?_____

What do you think will be helpful for your child?_____

What do you hope to gain from this evaluation?_____

Any additional comments or questions?_____

Completed by:_____

Print first and last name signature date

Relationship to child:_____