CONFIDENTIAL CASE HISTORY QUESTIONNAIRE

HELPING HANDS
PEDIATRIC THERAPY

Identifying Information:
Child's Name: **Birth Date:** **Today's Date:**
Address:
City: State: Zip:
Parents' Names:
Home Phone: Cell Phone: Business Phone:
Email address:
Names and ages of family members:
Name: Age: Relationship:
Name: Age: Relationship:
Name: Age: Relationship:
Name: Age: Relationship:
Child lives with: (circle) both parents father mother other:
Person to contact in an emergency:
Child's Physician/Pediatrician: **Phone:**
Medical Diagnosis:
Other Physicians/Specialists/Professionals working with your child:
Name: Phone:
Name: Phone:
Name: Phone:
Insurance Information:
Insurance Company:
Person Insured: Date of Birth:
Insurance Address:
Insurance Phone number:
Group Number: Policy Number:
Medicaid/Peachcare Number:
Referral Information:
Referred By:
Describe your concerns and the nature of the problem:
Has your child received any interventions or services up to this date? Please describe:

Child's Birth History and Development:					
Prenatal:					
Is your child adopted? If so, at what age?					
Did mother have any infections, illnesses, injuries or other complications during pregnancy? If yes, please describe.					
Any medications taken during pregnancy or delivery?					
Birth and Infancy:					
Location of Birth: Birth weight:					
Was pregnancy full-term?					
Was labor (circle answers that apply) normal? short? prolonged? induced?					
Was delivery (circle answers that apply) normal? breech? caesarean? forceps used?					
Was child incubated? If yes, how long?					
Were there any other complications at birth? (circle answers that apply) jaundice? transfusions?					
breathing difficulty? feeding difficulty? Apgar score? Other:					
Describe any congenital defect:					
As an infant did the child seem: (circle answers that apply) happy? cry frequently? sleep long hours?					
wake often? feed slowly? eat well?					
like being rocked? fuss when held?					
colicky? difficult to soothe?					
difficult to get to sleep? difficult to hold/cuddle?					
Motor Development					
At what age did your child do the following?					
roll over - crawl - sit alone - walk -					
drink from cup - chew solid food - eat with utensils - tie shoe laces -					
Was crawling phase prolonged, brief or almost entirely eliminated?					
Can your child do the following? If yes, indicate the quality of child's performance:					
	No	**Yes**	**Poor**	**Average**	**Good**
Hop on one foot					
Skip with both feet					
Climb on and over objects					
Jump with both feet together					
Ride a tricycle					
Ride a bicycle, with or without training wheels					
Jump rope					
Roller-skate					
Kick a ball					
Pump self on swing					
Cut with scissors					

Motor Development continued… Can your child do the following? If yes, indicate the quality of performance:					
	No	**Yes**	**Poor**	**Average**	**Good**
Color inside lines					
Play with puzzles and manipulative toys					
Have consistent hand dominance					
Blow soap bubbles					
Blow whistles					
Suck through a straw					
Medical History					
Has your child had any history of the following? If yes, please describe and give dates.					
Childhood diseases or major illnesses?					
Surgery?					
Serious injury?					
Casts or braces?					
Allergies?					
Frequent ear infections?					
Dietary restrictions?					
Is your child currently taking any **medications**? (If yes, please list the medication(s) names and state what					
condition the medication is treating:					
Has your child ever had a psychological, developmental, neurological, psychiatric, or EEG/MRI evaluation? If so,					
why and what were the results?					
Speech and Language Developmental History					
At what age did your child do the following?					
Say single words? What were his/her first words?					
Put 2-3 words together in a phrase?					
How many words does your child currently use? (circle the answer that applies):					
0-5 10-20 20-50 50-100 >100					
What is your child's primary way to make his/her wants and needs known? (e.g., gestures, pointing, sounds,					
one or two words, etc.):					
Is your child difficult to understand at times?					
Does your child understand and/or speak another language other than English? If yes, which is the predominant					
language at home?					

Fluency
Does your child stutter or stammer?
How long have you observed dysfluencies?
Is your child aware/concerned/frustrated?
Voice
Does your child's voice exhibit any of the following qualities? (circle answers that apply)
hoarse? harsh? nasal? very soft? very loud? other?
Feeding
Have there been any feeding problems?
Any problems with sucking, chewing, choking or swallowing?
Are the child's food preferences a concern?
Have there been any problems with liquids?
What are some of the foods that are typical in child's diet?
Social Development and Play Skills
Describe your child's personality:
Describe any social problems your child has with friends or family:
What are his/her favorite activities/toys/games?
Does your child play appropriately with these toys?
How long does he/she play with one toy?
Whom does child prefer to play with?
What makes child smile and laugh?
What play activities does child least enjoy?
How does child play when left alone?
What does child do when angry or frustrated?
Does your child tend to play with things by lining them or piling them up?
Please describe any other concerns you may have regarding your child's social skills or play skills:

Activities of Daily Living					
What self help skills does your child have? (Please use the following letter code: **U** - Unable, **I** - Independent,					
A - needs assistance, **S** - needs supervision only)					
Dresses self					
Undresses self					
Toilets self					
Brushes teeth					
Washes hands					
Feeds self					
Drinks from cup					
Zips zippers					
Buttons					
Snaps & hooks					
Puts on shoes					
Laces shoes					
Ties shoes					
Sensory History					
Has your child had a hearing examination?		Date of last testing:			
Who was the test performed by?		Results of hearing test?			
Has your child had an eye examination?		Date of last testing:			
What were the results of the eye exam?					
Does your child wear glasses?					
Are there sounds that your child particularly likes or dislikes?					
Are there textures that your child likes or dislikes?					
What foods does your child particularly dislike?					
What odors does your child particularly like or dislike?					
Please review the sensory list below and make an **X** mark below the column that best describes your child:					
Does your child:					
	Never	**Seldom**	**Sometimes**	**Often**	**Always**
Respond negatively to loud noises?					
Miss hearing some sounds?					
Unable to follow 2 or 3 directions given at once?					

Sensory History continued…					
Does your child:	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
Have difficulty paying attention when there is other noise present?					
Like to sing or dance to music?					
Have difficulty copying rhythms?					
Have difficulty remembering what is said?					
Have speech or articulation problems?					
Avoid hard or crunchy food textures?					
Keep an open mouth posture at rest?					
Suck his/her thumb or fingers?					
Mouth toys/objects?					
Avoid putting hands in messy substances?					
Dislike being touched unexpectedly?					
Tend to feel pain when hurt?					
Show sensitivity to clothes or tags?					
Prefer to touch rather than be touched?					
Pinch, bite, or otherwise hurt self?					
Bang head on purpose, now or in past?					
Avoid using hands for extended periods?					
Blink at bright lights?					
Reverse letters or numbers?					
Like to be in the dark?					
Have difficulty with eye contact?					
Rock in bed, now or in past?					
Spin or whirl more than most children?					
Jump a lot?					
Seem fearful of space?					
Get car sick?					
Like fast movements?					
Have trouble learning to climb stairs?					
Walk on toes, now or in past?					
Appear clumsy or fall often?					
Have poor motor coordination with small things?					
Have an awkward grasp with a pencil?					
Appear to have normal sense of taste?					
Appear to have normal sense of smell?					
Tend to explore orally or with smell?					
Have trouble learning urinary control?					
Have trouble learning bowel control?					
Have trouble with bed wetting?					
Seem sensitive to criticism?					
Hesitate to try new tasks?					
Have definite fears?					
Have temper tantrums?					

Display affection for others?					
Sensory History continued…					
Does your child:	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
Difficulty falling asleep or staying asleep?					
Impulsivity or hyperactivity?					
Unusually distractible?					

Are there any specific questions you have about your child that you would like us to address through our assessment? What would you like for your child to achieve?

Signature:

Relationship to child:

Date: