Pediatric Case History Form

General Information:

Child's Name: ______________________ Sex: ___ Date of Birth: __________ Age: ___

Place of Birth: ___________________ School: ______________________ Grade: ____

Parent/Guardian completing this form: ______________________________

Parent/Guardian Information:

Parent/Guardian #1: _______________________ Phone Number: _________________

Occupation: ______________________ Alternative phone number: _______________

E-mail Address: ____

Parent/Guardian #2: _______________________ Phone Number: ________________

Occupation: ______________________ Alternative phone number: _______________

E-mail Address: ____

Family & Home Information:

Home Address: ____
(Street) (City/State/ZIP)

Please list all persons living in the home:

Name:	Age:	Relationship to Child:

Language(s) spoken at home: ____

How long has your child spoken English?: ___________________________________

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Medical History:

Pediatrician's Name: ____

Pediatrician's Address: ____
(Street) (City/State)

Please indicate at which age your child has had any of the following:

Measles ____________ Chicken Pox _____________ Asthma _____________

Meningitis ____________ Seizures ______________ Allergies _____________

Tonsilitis ______________ Earaches _______________

Please list any serious injuries, high fevers, seizures, hospitalizations, surgeries, neurological events, diseases, physical handicaps, or other medical information that you think may be relevant. Please give dates or approximate ages for each event:

____

____

____

Please list any medications taken:

Medication:	Frequency/Dose:	Reason:

Does your child currently see any other specialists (e.g. physical therapist, occupational therapist, psychologist, psychiatrist, ENT, neurologist)? If yes, please list below:

____

____

Is there family history of learning disorders, speech/language disorders, anxiety/depression, ADHD, or Autism Spectrum Disorder? If yes, please list below:

____

____

When was your child's last hearing test? (include results): _________________

When was your child's last vision test? (include results): ___________________

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Prenatal and Birth History:

(If child is not your biological child, please complete to the best of your ability)

Is this child your: __ biological child __ step child __ adopted child __ foster child

If child was adopted please indicate age at adoption and country of adoption.

____

During this pregnancy, did the mother have (please answer yes or no):

Prenatal care _____ Measles _____ Bleeding _____ Falls/Accidents _____

RH incompatibility _____ Use of Tobacco _____ Use of Alcohol/Drugs ______

Please list any medications the mother took during pregnancy:

Medication:	Dose/Frequency:	Reason:

Is there a history of miscarriages or stillbirths? ______________________________

Length of pregnancy: ________months Duration of labor: _______hours

Type of Delivery (natural, breech, cesarean): ______________________________

Method of Delivery (natural, induced, forceps): _____________________________

Birth weight (lb/oz.): __________________ Hospital of Delivery: ________________

Please list any complications during pregnancy/delivery:

____

____

____

Did the baby have any of the following? jaundice, difficulty breathing, difficulty feeding, surgery?:

____

____

Developmental History:

Please indicate the age for the following:

First Tooth _____________ Sat Alone _____________ Crawled ____________

Walked Alone ___________ Potty Trained ___________ First Babbled ____________

First Words (age & words) ____

First Phrases or Sentences (age & words)

____

____

Please indicate each of the following with yes/no response:

Did child have difficulty learning to ride a bicycle? ______

Does child fall or lose balance easily? ______

Does child have difficulty grasping objects? ______

Does child have difficulty sipping through a straw? ______

Does child have any difficulty chewing or swallowing? ______

Does child have any difficulty imitating arm movements? ______

Does child have any difficulty imitating movements of facial expression? ______

Does child play with other children? ______

Does child feed him/her self? ______

Does child dress him/her self? ______

Does child sleep throughout the night? ______

Does child seem to understand when spoken to? ______

Does child have difficulty talking about his/her ideas using words? ______

Is child able to concentrate on one activity? ______

Is child able to separate from parent/caregiver? ______

Please provide any additional, relevant information about any of the above:

____

____

____

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Social Information:

What are some things that your child is good at?:

____
____
____

What are some of your child's interests/hobbies?:

____
____
____

How does your child interact with other children? (Describe frequent fighting, difficulties obtaining or keeping friends, preferences to be around younger or older children, etc.):

____
____
____

Describe your child's friendships:

____
____
____

How does your child get along with adults?

____

Have you noticed any unusual social interactions? _____ Yes ____ No

If yes, please describe:

____
____
____
____

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Behavioral Information:

Please place a check next to any behavior or problem that your child currently exhibits.

- ☐ Uses alcohol
- ☐ Uses drugs
- ☐ Smokes cigarettes
- ☐ Is cruel to animals
- ☐ Sets fires
- ☐ Prefers to be alone
- ☐ Is aggressive
- ☐ Is shy or timid
- ☐ Is clumsy
- ☐ Sucks thumb
- ☐ Is slow to learn
- ☐ Bites nails
- ☐ Does not like to be touched
- ☐ Difficulty concentrating
- ☐ Does not recognize personal space of others
- ☐ Is more interested in things than in people
- ☐ Seeks stimulation from touching/feeling others/objects
- ☐ Engages in behavior that could be dangerous to self or others
- ☐ Has trouble sleeping. If yes, please describe: ______________________________
- ☐ Has special fears, habits or mannerisms. If yes, please describe: _______________________
- ☐ Has frequent tantrums
- ☐ Has frequent nightmares
- ☐ Rocks back and forth
- ☐ Bangs head
- ☐ Holds breath
- ☐ Eats poorly
- ☐ Is stubborn
- ☐ Has poor bowel control (soils self)
- ☐ Wets bed/self
- ☐ Is much too active
- ☐ Is impulsive
- ☐ Has blank spells
- ☐ Gives up easily
- ☐ Is easily frustrated
- ☐ Does not like loud noises
- ☐ Can't keep hands to self
- ☐ Memory problems
- ☐ Repeats actions over and over

Please describe any other unusual behaviors:

____

____

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Current Speech/Language Concerns:

Please check any of the following areas of communication in which you feel that your child needs help:

- ☐ Understanding language
- ☐ Expressing language
- ☐ Speech sounds
- ☐ Fluency/Stuttering
- ☐ Voice
- ☐ Social Communication

Statement of the problem (In your own words, what difficulty is your child having?):

____

____

____

____

When was the problem first noticed?: ______________________________

Does the problem vary? Is it better or worse at certain times?:

____

____

____

Has the child received any special services at school or other clinics and/or hospitals (speech therapy, reading assistance, special class, visual, hearing, psychological evaluations, medical, etc.)? If so, please list below:

Type of Service:	School or Specialist:	Dates:

What questions would you like to have answered by this evaluation?

____

____

What would you like your child to be able to do that they cannot do currently?

____

____

____

____

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