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School-Age Case History Form

General Information:

Child's Name: _____ Date of Birth: _____

Gender: M ___ F ___ Diagnosis (if any): _____

Parents' Names: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ Cell: _____ Work: _____

Email Addresses: _____

Legal Guardian (if other than parent): _____

Please list other members of the household:

Name	Age	Relationship to Child
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

** Is there any history of speech/language, gross motor, fine motor, learning, or developmental problems in the immediate family or mother's/father's families: Yes _____ No _____.

If yes, please explain: _____

Medical History:

Length of pregnancy: _____ Complications during pregnancy: Yes _____ No _____

If yes, please explain: _____



Complications at birth/delivery: Yes _____ No _____ If yes, please explain: _____

In NICU: Yes _____ No _____ If yes, how long: _____

Has your child had any major accidents/illnesses/hospitalizations? Yes _____ No _____

If yes, please explain: _____

Has your child had any ear infections/tubes? Yes _____ No _____ . How many? _____

Has your child ever received PE tubes? Yes _____ No _____ .

Has your child ever has tonsil and/or adenoid issues? Yes _____ No _____ .

Please list all current medications that your child is taking and what condition they are indicated for: _____

Please list any allergies your child has: _____

Describe your child's sleep pattern: _____

Pediatrician's name/Practice: _____

Pediatrician's phone: _____ fax: _____

Oral Development:

Please indicate (✓) if your child does/has the following:

Uses pacifier/sucks fingers or thumb: _____

"Tongue tie" or a short lingual frenulum: _____

Repaired cleft palate or cleft lip: _____

Is your child a picky eater? Yes _____ No _____

If yes, please explain: _____

Does your child gag, choke, or vomit with any foods? Yes _____ No _____ .

Do you have any concerns about your child's feeding skills? Yes _____ No _____ .



Developmental History:

Please provide the approximate age at which your child began to do the following:

Walk: _____

Use single words: _____

Name simple objects: _____

Ask/answer questions: _____

Combine words into phrases/sentences: _____

Engage in conversation: _____

Current Communication:

Does your child.....

_____ understand what you are saying?

_____ follow multi-step directions (e.g., "get your shoes" AND "shut the door")

_____ respond correctly to *what/where/who/when/why* questions?

How does your child communicate at this time? *Please check all that apply*

_____ Sign language

_____ Single words

_____ Gestures or Pointing

_____ 2-3 word phrases

_____ 4+ word sentence

_____ Conversation

Behavioral characteristics: *please check all that apply*

Cooperative

Restless

Attentive

Poor eye contact

Willing to try new activities

Easily distracted/short attention

Plays alone for reasonable length of time

Destructive/aggressive

Separation difficulties

Withdrawn

Easily frustrated/impulsive

Inappropriate behavior

Stubborn

Self-abusive behavior

Educational History:

Child's current placement: Home _____ Daycare _____ School _____ Grade level: _____

Name of school/ City: _____

Is your child having a hard time with any subjects in school? Yes _____ No _____.

If yes, please explain: _____

Has your child ever been evaluated for or received the following services?

Speech Therapy _____ Occupational Therapy _____ Physical Therapy _____.

Please list all previous and current therapies received:

Where received?

Length/ Dates of Treatment:

Current Concerns:

Please describe your concerns today: _____

When was the problem first noticed? _____ By whom?: _____

What do you hope we can accomplish in therapy? _____

*Thank you for your assistance in completing this form.
This information is confidential and will be used strictly for therapeutic purposes.*

Person Completing this Form: (please print) _____

Signature: _____ Date: _____

Relationship to Child: _____