My Recess Inc. THERAPY

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CASE HISTORY FORM

Date: _____ Evaluating Therapist: _____

Child's Name: _____ Date of Birth: _____

Parents/Guardians: _____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone(s): _____

Work Phone(s): _____

Parents Profession: _____

Email(s): _____

Sibling(s) Names and Ages: _____

Please check which methods of communication are acceptable for discussing treatment appointments as well as information regarding treatment and evaluation results?

☐ Cell Phone ☐ Text Message ☐ Email ☐ Home Phone

☐ I agree to receive communication from My Recess Therapy through the above methods. I understand I am responsible for additional data charges imposed by my service provider and acknowledge My Recess Therapy is not liable for any compromised privacy by my email provider/host, Internet service, cell-phone or data service.

Name of referring physician: _____

Reason for referral? _____

Medical diagnosis: (if applicable) _____

Who can we thank for referring you to My Recess Therapy? _____

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DEVELOPMENTAL HISTORY

PRENATAL HISTORY

Pregnancy: # of Weeks _____

Normal/Problems:
(describe) _____

_____

_____

Birth Weight: _____ Apgar Score: _____

Labor: ____ Normal ____ Induced

Special Considerations: ____ Cesarean ____ Premature ____ Breech

____ Child Rotated ____ Cord Around Neck ____ Other:

Hospital Stay: Mother _____ Child _____

If child was adopted, please give as much information as possible about the child's biological mother and family history

_____

_____

_____

Was your child breast fed and if so for how long? _____

Did your child enjoy tummy time? _____ Explain: _____

_____

_____

DEVELOPMENTAL MILESTONES

At what age did your child:

_____ Sit-up without support _____ Crawl _____ Walk

_____ Run _____ Use words _____ Sentences

_____ Drink from a cup _____ Use spoon, fork, knife _____ Dress self

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SPEECH THERAPY FORM

HISTORY

Has your child's speech and/or language skills been evaluated previously? Yes ☐ No ☐

If so, where _____

What were the results and recommendation? _____

Has your child received speech-language therapy previously? Yes ☐ No ☐

Please describe where, when, and what was addressed

_____

_____

DEVELOPMENTAL MILESTONES

Did your child babble as an infant? Yes ☐ No ☐

Please tell the approximate age your child achieved the following milestones:

Babbled ____ Put two words together ____

Said first words ____ Spoke a short sentence ____

Did your child's speech and language skills progress at a consistent rate Yes ☐ No ☐

GENERAL INFORMATION

Describe in your own words what problem your child is having with speech and/or language? Be specific.

_____

_____

How does your child typically communicate? Please describe.

_____

_____

Is your child able to imitate speech sounds? words? phrases? Yes ____ No ____

Do you have concerns with your child's ability to understand language? Yes ____ No ____

Does your child respond to simple directions? Yes ____ No ____

Answer yes/no questions accurately? Yes ____ No ____

Answer "wh" questions accurately (who, what, where, when, why)? Yes ____ No ____

Does your child do any of the following:

Choke on foods or liquids? Yes ____ No ____

Put toys/objects in his or her mouth? Yes ____ No ____

Brush teeth and/or allow brushing? Yes ____ No ____

MEDICAL HISTORY

Please list any doctors that currently follow your child (MD, ortho, psychiatrist etc.)

Any history of surgeries: If so elaborate and include dates

Does your child have any allergies? If so when and by whom were they diagnosed?

Is you child currently taking any prescription medications, supplements, or over-the-counter medication? Please list dose and frequency.

Does your child have history of ear infections?

Has your child had his/her hearing tested? Results?

Has your child had a visual exam? If so, when and what were the results?

Is your child currently receiving any other special services through school or privately? (Physical therapy, speech therapy, psychology, tutoring include names of other professionals, frequency and duration.)

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EDUCATIONAL HISTORY

What is your child's current grade? _____ Teacher's Name: _____

What school does he/she attend? _____

Please list other schools attended _____

Does you child have an Individualized Education Plan (IEP)? _____

If yes, what services are included in the IEP? Please list frequency of services: _____

Does your child have any difficulty with reading? _____

BEHAVIOR/SOCIAL HISTORY

Describe your child's social interaction with other children

Describe your child's tolerance for challenging or frustrating tasks

How does your child do when making transitions between activities, environments, or when there are unexpected changes in plans/expectations

Does your child prefer to engage in solitary and/or parallel play?

Does your child participate in any community based activities (karate, scouts, etc). Please list frequency and duration (i.e. Soccer June- Sept 1x weekly)

Describe your child's play skills. Include his/her interests, favorite toys/games, pretend themes used in play, etc.

Can he/she engage in pretend play alone/with others/with an adult?

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SELF-CARE/DAILY ROUTINES

Do you have any concerns related to your child's diet?

Please List
Foods you child eats regularly

Foods your child used to eat but no longer eats

Are there sensitivities to taste, explain

Are there sensitivities to texture, explain

Are there sensitivities to temperature, explain

Are there concerns with your child's ability to bite, chew, move food around in the mouth, or swallowing, explain

Please describe your child's sleep habits (Include bedtime routine, # of hours, # naps if any)

Please describe how your child typically gets dressed. (Include how much assistance is needed, length of time, preference for certain fabrics/avoidance of textures)

Can your child
____ fasten snaps ____ buttons ____ zippers
____ buckles ____ velcro enclosures ____ tie shoes

SELF-CARE/DAILY ROUTINES *(CONTINUED)*

Please describe bath time for your child (level of independence, like/dislike, preference for a bath or shower)

Please describe your child's ability/tolerance of:

Brushing teeth

Brushing hair

Washing hands/face

Is your child toilet trained? ___ YES ___ NO If so, when did this occur? _____

Please describe if there were/are any problems with toileting

Please describe you child's ability to keep track of personal belongings

Please describe your child's ability to independently organize his/her bedroom, backpack, desk

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ATTENTION/SELF-REGULATION

Does your child have a difficult time calming down to go to sleep or waking up in the morning? If so, please explain

Is your child irritable at predictable times of the day? If so, what events trigger this and when does it occur?

Does your child seem happier or more cooperative at predictable times of the day? Please describe

Does your child exhibit any impulsiveness, aggression, or immaturity more than other children his/her age? If so, please explain

Describe your child's ability to attend to activities (responding to his/her name or a question in a timely manner, table top tasks -vs-gross motor activity-vs-homework)

MOTOR SKILLS

Please describe your child's fine motor and visual motor skills (manipulation of small objects and toys/ dexterity, grasp on pencils/crayons, control/accuracy, quality of writing)

Can your child ride a bicycle (tricycle or two wheeler)

Please describe your child's performance on jungle gym type equipment (preferences, tolerance for swings, climbing, level of independence

PARENTAL CONCERNS

What do you feel are your child's strengths?

What are your concerns?

What do you hope will be gained by having this evaluation and occupational therapy treatment if recommended?