My Recess Inc. THERAPY

1601 E Main Street, Unit G, Saint Charles IL 60174
2018 Larkin Avenue, Elgin, IL 60123

630.880.0993 (office)
630.480.4049 (fax)
info@myrecess.com

CASE HISTORY FORM

SECTION 1: PATIENT AND REFERRAL INFORMATION

Please email a completed form to info@myrecess.com **at least one week** before your child's evaluation. This allows your therapist time to review the information carefully and prepare a meaningful, individualized assessment experience for your child.

Date _____

Child's Name: _____ Date of Birth: _____

Date of Evaluation: _____ Therapist: _____

Location: ☐ Elgin ☐ St. Charles ☐ Other

Primary Caregivers(s): _____

Relationship: _____ Email: _____

Address: _____

City/State/Zip: _____

Phone: Cell _____ Home _____ Work _____

Preferred Communication ☐ Text ☐ Email ☐ Phone ☐ Other

Siblings (Name & Age)

Referring Physician: _____ Reason for Referral: _____

Diagnosis/ICD-10 _____ Referred By: _____

My Recess Inc.
THERAPY

SECTION 2: BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy: # of Weeks No Complications Complications

Describe:

Labor: ____ Normal ____ Induced ____ Vaginal
____ Cesarean ____ Breech ____ Premature

Hospital Stay: Mother _____ Child _____

Breastfed: ____ Yes ____ No Duration _____

Tummy Time: Enjoyed ____ Yes ____ No

Developmental Milestones(Age in Months)

_____ Sit _____ Crawl _____ Walk
_____ Run _____ Words _____ Sentences
_____ Drink _____ Utensils _____ Dress

My Recess Inc.
THERAPY

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.

My Recess Inc.
THERAPY

Speech Therapy General Information *continued ...*

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 ever exhibit any of the following behaviors: repeat part of a word, repeat a whole word, have difficulty getting words out, pause excessively when talking?	Yes ____	No ____
Does your child's voice sound more rough / hoarse / breathy then their peers? Or does your child sound like he/she always has a stuffy nose?	Yes ____	No ____
Does your child ever struggle to position their tongue / lips / jaw to produce speech sounds?	Yes ____	No ____
Does your child's speech clarity decline when he/she tries to say longer words/ sentences?	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 ____

My Recess Inc.
THERAPY

SECTION 4: PREVIOUS EVALUATIONS AND SERVICES

List prior therapies/services, dates, frequency, and focus:

Attach most current reports (neuropsychological testing, early intervention evaluations)

SECTION 5: MEDICAL HISTORY, TREATMENT HISTORY AND CHIEF COMPLAINT

Primary Physician: _____ Specialists: _____

Surgeries (dates/outcomes) _____

Allergies: _____

Medications/Supplements: _____

SCREENINGS

Hearing Test:	☐ Passed	☐ Failed
Vision Test	☐ Passed	☐ Failed
Ear Infections	☐ Yes	☐ No

SECTION 6: SCHOOL PERFORMANCE AND SUPPORTS

Grade: _____ School: _____

Teacher: _____ Teacher Email: _____

Academic Level	☐ At	☐ Below	☐ Above
Strengths:	☐ Reading	☐ Writing	☐ Math
	☐ Social	☐ Other	
Challenges:	☐ Focus	☐ Transitions	☐ Organization
	☐ Behavior	☐ Other	
IEP/504	☐ Yes	☐ No	

If yes, please provide details and comments on school performance (Please attach IEP)

My Recess Inc.
THERAPY

SECTION 7: BEHAVIOR AND SOCIAL DEVELOPMENT

Peer Interaction:	☐ Engages	☐ Prefers Familiar	☐ Solitary	☐ Avoids
Play Type:	☐ Cooperative	☐ Parallel	☐ Pretend	☐ Competitive
Regulation:	☐ Manages Well	☐ Easily frustrated	☐ Withdraws	☐ Aggressive
Transitions:	☐ Adapts	☐ Needs Reminders	☐ Upset	☐ Relies on Routine

Community Activities:

SECTION 8: MOTOR SKILLS

Concerns related to motor skills ☐ Yes ☐ No

Describe:

Gross Motor:	☐ Confident	☐ Cautious	☐ Avoids	☐ Seeks Movement
Fine Motor:	☐ Typical	☐ Immature Grasp	☐ Avoids Writing	☐ Manipulates small objects
Hand Dominance:	☐ Right	☐ Left	☐ Mixed	
Visual Motor:	☐ Copying	☐ Catching	☐ Puzzles	☐ Writing with Appropriate Spacing
	☐ Reading			

SECTION 9: PLAY SKILLS

Concerns related to play skills ☐ Yes ☐ No

Describe:

What type of play does your child enjoy:

☐ Pretend ☐ Construction ☐ Active ☐ Art ☐ Music
☐ Puzzles ☐ Sensory ☐ Screens

Play Style: ☐ Alone ☐ Parallel ☐ Takes Turns ☐ Cooperative

Engagement: ☐ < 5 min ☐ 5-15 min ☐ 15+ min

Notes:

SECTION 10: REFLEXES AND MOVEMENT PATTERNS

Concerns related to the following movement patterns: ☐ Yes ☐ No

☐ Balance ☐ Crossing Midline ☐ Crawling/Skipping ☐ Biking ☐ Coordination

Position Preferences: ☐ W-sit ☐ Lies on Floor ☐ Avoids Tummy Time

Observations: ☐ Easily Startled ☐ Motion sensitive ☐ Low tone ☐ Stiff/Rigid

Evaluated for Reflexes: ☐ Yes ☐ No

Comments:

SECTION 11: AREAS OF OCCUPATION – DAILY ROUTINE AND SELF-HELP

Concerns related to daily routines: ☐ Yes ☐ No

Describe:

Morning Routine Notes:

Self-Care Skills (Task: Dressing, Bathing, Brushing, Toileting, Feeding)

☐ Independent ☐ Needs Help ☐ Avoids

Self-Care Skills Notes:

Sleep times Bedtime Wake

☐ Good ☐ Difficult ☐ Restless

Chores/Participation:

SECTION 12: EXECUTIVE FUNCTIONING

Concerns related to executive functioning skills: ☐ Yes ☐ No

Describe:

Attention/Focus:	☐ Needs Reminders	☐ Finishing Tasks	☐ Ignores Distractions	☐ Multi-step Directions
Organization/Planning	☐ Backpack	☐ Routines	☐ Planning Ahead	☐ Clean Up
Time:	☐ Understands Time	☐ Poor Estimation	☐ On Time	
Self-Monitoring/ Problem Solving:	☐ Notices Mistakes	☐ Impulsive	☐ Needs Reminder	☐ Takes Adults' Ideas

My Recess Inc.
THERAPY

SECTION 13: PARENTAL CONCERNS AND STRENGTHS

Child's Strengths:

Main Concerns/Goals for Therapy :

Family Priorities

- ☐ Independence
- ☐ Fewer Meltdowns
- ☐ Confidence
- ☐ Routine Ease
- ☐ Participation
- ☐ Communication
- ☐ Social Skills
- ☐ Motor Skills
- ☐ Developmental Milestones

PARENT/GUARDIAN ACKNOWLEDGMENT & ELECTRONIC SIGNATURE

Parent or Legal Guardian's Signature

Date

Electronic Signature (Type Full Name)

Additional Comments: