PEDIATRIC CASE HISTORY

I. General Information

Child's Name:____ DOB:_____________________

Mother's Name: ____

Father's Name: ____

Address:____

City, State, Zip:____

Preferred Contact Number:____

Referring Physician:____

Referring Physician's phone number: ____

Physician's Address:____

Physician's fax number:____

Self Pay: yes no

Insurance Company:______________________________ ID number: _____________________

Group Number:____

Primary Insurance Holder's name:____

Medicare Number____

Name of School: ____

School Phone Number: ____

Teacher's Name: ____

Grade or Program: ____

Has your child had an IEP? yes no

Does your child have an IEP? yes no

Child's Name: ___________________________ DOB: _______________

II. Medical History and Prenatal History (Please circle answers when appropriate)

Please indicate whether your child has suffered from the following illnesses/conditions:

Allergies	Y / N	Asthma	Y / N	Chicken Pox	Y / N
Colds	Y / N	Convulsions	Y / N	Croup	Y / N
Dizziness	Y / N	Draining Ear	Y / N	Ear Infections	Y / N
Encephalitis	Y / N	German Measles	Y / N	Headaches	Y / N
High Fever	Y / N	Influenza	Y / N	Mastioditis	Y / N
Measles	Y / N	Meningitis	Y / N	Mumps	Y / N
Pneumonia	Y / N	Seizures	Y / N	Sinusitis	Y / N
Tinnitus	Y / N	Tonsillitis	Y / N	Other	Y / N
Down Syndrome	Y / N	Autism/PDD	Y / N	Cerebral Palsy	Y / N
Vocal Nodules	Y / N	Developmental Delay	Y / N	Encephalopathy	Y / N
Hearing Loss	Y / N	Stuttering	Y / N	ADD/ADHD	Y / N

1. Please explain your concerns regarding your child. What prompted you to bring your child for an evaluation today?

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____
____

2. With what medical conditions has your child been diagnosed? ___________________

____
____
____
____

3. Please list all doctors and specialists involved in the care of your child. Include contact information including name of facility, phone, fax and email.

Doctor	Specialty	Facility	Phone #	Fax #	**E-mail**

4. Please provide results from *any* testing your child has undergone (i.e. medical, genetic testing, neurological, psychological, audiological, etc.).

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____
____

Child's Name: ___________________________ DOB: _______________

5. Has it been recommended for your child to see any other specialists? Please explain.

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6. Please list any allergies to which your child is susceptible. (Remember: a variety of foods (i.e. peanuts), therapy materials (i.e. latex), and cleaning products are present within this office.)

____

7. How are reactions managed? ____
____

8. List any inoculations your child has had.

____
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9. List any childhood illnesses your child has had.

____
____

10. Prenatal History: Were there any complications that may have affected the pregnancy or birth?

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Please indicate:
Length of Pregnancy_________
Vaginal Delivery: Yes/No, if yes length of delivery________
Head first ____ Feet first_____
Caesarian Delivery: Yes/No, if yes length of delivery________
Breech________ Fetal distress_______

11. During delivery, was any assistance needed (i.e. forceps, position of umbilical cord, repositioning)?____

12. Please describe your child's general condition following delivery (include Apgar Scores).

____

13. Did your baby require the Neonatal Intensive Care Unit (NICU)_________________

14. If so, how long was your baby hospitalized?

____

15. Please provide any additional information about your child's hospitalization:

____
____
____

Child's Name: ___________________________ DOB: _______________

16. Is your child being followed by a medical team? Have they been followed by a team in the past? Please explain. (Cardiology, craniofacial, implant, psychology, etc.)

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17. Is your child on any medications: Yes No
If yes, please provide the following information:

Medication	Dosage (amt and time of day)	**Reason for Medication**

18. Please indicate what type of hearing testing your child has undergone:
______ Acuity: child required to respond to a tone
Results:_________________ Date: __________ Location:__________________
______ Tympanometry: no response required from child
Results: _________________ Date: _________ Location: __________________

19. When was your child's vision last evaluated by an opthamologist?
Results:_________________ Date: __________ Location: __________________
When was your child's vision last screened?
Results:_________________ Date: __________ Location: __________________

20. Please provide the results of any medical testing including CT scans, MRIs, Pet Scan, or EMG testing your child has completed.

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21. Has your child ever had surgery? yes no
If Yes, please provide the following information for each surgery:

Type of Surgery	Reason	Date	Surgeon/Location	**Outcome**

Child's Name: ___________________________ DOB: _______________

22. Has surgery ever been considered as a treatment option but not performed? Please describe the recommendation and the reason it was not carried out?

____
____
____

23. Please list current medications and dosage: ---
____
____
____

III. Developmental History

1. Please provide the approximate ages at which your child accomplished the following activities.
Early Motor Development:
Crawl ______ Sit _______ Stand Independently _______ Walk Independently________
Dress Self_________________
Potty Trained ______________
Potty training in progress since __________
2. Does your child have difficulty running, walking, or participating in other activities that require small/large muscle coordination? Please describe.

____
____
____

3. Does your child have difficulty buttoning, zipping, or participating in other activities that require fine motor coordination? Please describe.

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____
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4. Please provide the approximate ages at which your child began the following activities:
Early Communication Development:
Babbling _____________________
Pointing to desired objects______________________________
Using at least 10 single words/approximation with meaning _______________________
Using approximately 50 words____
Naming objects and actions____
Combining 2-words____
Engaging in conversation with adult____
Initiating games/activities (i.e., peek-a-boo)___________________________________
Engaging in turn taking activities____
Sustaining attention to a short story ____

Child's Name: ___________________________ DOB: _______________

5. Please provide the approximate ages at which your child began the following activities:

Early Feeding Development:

Began to suck from nipple _______________ Began purees _______________________
Began finger foods ______________________Began table foods __________________
Drank from open cup___________________ Suck from straw _____________________
Feed self __________________________

6. Is your child hypersensitive to sounds or textures? If yes, please explain.

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____
____

7. How would you describe your child's interaction and communication with peers?

____
____
____

8. What opportunities does your child have to interact with other children?

____
____
____

9. How would you describe your child's interaction and communication with adults?

____
____
____

10. What is your child's primary language? _____________________________________

11. Please list all languages in which your child has been exposed. ________________
____

IV. Feeding History

1. Does your pediatrician have concerns about weight gain and growth?
   Current Height:_______________ Current Weight:_____________________

2. During infancy was your child breast fed____, Bottle fed_____, Tube fed______
   Type of Tube _______________

3. Is your child's current primary nutrition taken by mouth, tube, or both?
____

4. Does/Did your child use a pacifier? ______ For how long? ______

5. Does/Did your child suck their thumb or fingers?_________ For how long? ________

6. Do you see saliva build-up or wetness in your child's mouth? yes no

Child's Name: ___________________________ DOB: _______________

7. Unassociated with teething, do you notice saliva or drooling? yes no

8. How does your child intake liquid? Please check all that apply:
breast ____________ bottle __________ sippy cup___________
straw _____________ open cup _______ lidded cup with hole/slit____________

9. When drinking, has your child ever had difficulty containing liquid in their mouth? Does their chin appear wet after drinking? Do they continue to have difficulty?
____
____

10. Has your child ever had difficulty or refused to eat certain foods or consistencies? For example: purees, liquids, junior baby foods, table food, sticky foods (mashed potatoes), crunchy foods (carrots), chewy foods (meats), creamy foods (yogurt) , or mixed consistencies (cereal and milk)?
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____
____

11. Does your child overstuff their mouth or add more food before they finish was is already in their mouth?
____

12. Would you consider your child a picky eater? Please explain.
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____
____

13. Does your child:

Have their tonsils?	Y / N	Lick their lips?	Y / N
Have their adenoids?	Y / N	Prop their chin?	Y / N
Bite their fingernails?	Y / N	Have a strong gag reflex?	Y / N
Grind their teeth?	Y / N	Able to gargle?	Y / N

14. Has your child been (or is now) in an active orthodontic treatment program?
____
____

Voice History:

1. How would you describe your child's voice? __________________________________
____

2. Rate the following: (please circle)

My child yells:	often	sometimes	rarely	never
My child uses a loud voice:	often	sometimes	rarely	never
My child complains of a sore voice:	often	sometimes	rarely	never
My child's voice is hoarse:	often	sometimes	rarely	never
My child loses their voice:	often	sometimes	rarely	never

Child's Name: ___________________________ DOB: _______________

3. Has your child seen an ear, nose and throat specialist (ENT) as a result of his voice?

____

____

4. Has your child ever been diagnosed with a voice problem (i.e. nodules)? Please explain.

____

____

5. Following involvement in large group activities (i.e camp, sports, recess) does your child's voice sound different (i.e. hoarseness, roughness, strain, some voice loss)?

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____

Please provide any other information you feel would be important for us to know about your child.

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