

Midwestern University – Therapy Institute

Child Case History

Client Information

Date Completed:

Child's Name:

Date of Birth:

Medical Diagnosis:

Birth Sex: • Male • Female

Gender Identity:

• Male • Female • Non-Binary • Prefer to Self-Describe

Allergies:

Primary Language:

Parent/Guardian Information

Mother's Information

First Name:

Last Name:

Address:

City/State/Zip:

Please check the box next to the best number to reach you during the day:

• Home Phone: • Work Phone:
• Cell Phone:

Email:

Occupation:

Marital Status: • Single • Married • Divorced • Widowed

Child lives with this parent: • Yes • No

This parent is the preferred contact for scheduling questions: • Yes • No

Parental Status:

• Natural • Legal Guardian • Foster • Other

Father's Information

First Name:

Last Name:

Address:

City/State/Zip:

Please check the box next to the best number to reach you during the day:

• Home Phone: • Work Phone:
• Cell Phone:

Email:

Occupation:

Marital Status: • Single • Married • Divorced • Widowed

Child lives with this parent: • Yes • No

This parent is the preferred contact for scheduling questions: • Yes • No

Parental Status:

• Natural • Legal Guardian • Foster • Other

Name(s) and age(s) of any siblings:

Outpatient Therapy History

Therapy Type	Previous (Dates)	Current (Dates)	School based services?
Occupational Therapy			
Physical Therapy			
Speech-Language Therapy			
Vision Therapy/Visual Rehab			
ABA (Applied Behavior Analysis)			
Psychology/Behavioral Health			
Other:			

Birth/Developmental History/Medical Information

Mother's health during pregnancy:

Length of pregnancy:

Birth weight:

Method of Delivery:

- Vaginal
- Scheduled C-Section
- Emergency C-Section

Health of child at birth:

Length of hospital stay:

At what age (approximately) did your child achieve the following developmental milestones?

- Sitting unsupported (typical age 6 months)
- Crawling (typical age 6-9 months)
- First word(s) (typical age 11 months)
- Walking (typical age 12-15 months)
- Eating finger foods (typical age 6-9 months)
- Eating with a spoon (typical age 18-24 months)
- Two-word combinations (typical age 20 months)
- Toileting (typical age 3-4 years)

Has your child had any major accidents or hospitalizations?

- Yes
- No

Please explain:

Is your child currently taking any medications:

- Yes
- No

If yes, please describe:

School Information

Grade/Level:

School name:

District:

Type of Classroom:

- Regular Educational
- Self-Contained
- Resource Room
- Partial Inclusion
- Bilingual Education
- Virtual
- Homeschool

Support within class/school program:

- Full time 1:1 aide
- Part time 1:1 aide
- Classroom aide
- Nurse
- None needed

Easiest subject:

Most difficult subject:

Any grades repeated?

Academic setting:

- Mainstream
- Gifted
- Special Education

Does the school consider your child to have:

- Learning problems
- Disciplinary problems
- None

Behavior

Does your child have behavior management needs?

- Yes
- No

If yes, please describe:

How do you typically manage behavior?

Mobility, Seating, and Positioning

How does your child get from one place to another? (please check all that apply)

- Walks independently
- Walks with assist
- Stroller
- Walker
- Scooter
- Manual wheelchair
- Motorized wheelchair
- Other

Please describe any special concerns about mobility/seating/positioning:

Hearing

Do you feel that your child has a hearing problem?

- Yes
- No

If yes, please describe:

Has your child ever had his/her hearing tested?

- Yes
- No

What were the results?

Does your child have a history of ear infections?

- Yes
- No

Frequency:

Age of occurrence:

Has your child ever had tubes placed in his/her ears?

- Yes
- No

Reason:

Results:

Concerns: Please check all below that describe the concerns you have for your child.

Occupational Therapy

- Difficulty sitting still
- Sensory sensitivity (bright lights, loud noises, difficulty with grooming or the feeling of clothing)
- Social anxiety
- Handwriting
- Self-care skills (buttons, zippers, dressing and undressing themselves)
- Tying shoes
- Poor attention at school
- Behaviors/meltdowns
- Feeding difficulties
- Other: (please describe)

Speech and Language

- Difficulty making speech sounds
- Difficulty understanding language/following directions
- Difficulty putting words/sentences together
- Speaks, but has a small vocabulary
- Need for another method to communicate (picture book, technology, etc.)
- Stuttering
- Feeding or swallowing difficulties
- Voice issues
- Other: (please describe)

Visual Rehabilitation Services

- Headaches with near work
- Words run together while reading
- Burning, itchy, or watery eyes
- Skipping/repeating lines while reading
- Tilting head or closing one eye when reading
- Difficulty copying from a chalkboard
- Avoiding near work or reading
- Omitting small words when reading
- Writing uphill or downhill
- Misaligning digits/columns of numbers
- Poor reading comprehension
- Holding books or near work very close to eyes
- Short attention span with near work
- Difficulty completing assignments on time
- Saying "I can't" before trying something
- Clumsiness and knocking things over
- Losing belongings or misplacing things
- Forgetting things
- Difficulty spelling
- Excessive eye rubbing
- Child performs better when being read to

Note: If you checked a concern in any of the above categories, please complete the corresponding addendum on the following pages. You may skip the forms that do not apply.

Child Case History Speech Addendum

What language is used most often at home?

By whom:

Are there any other languages spoken in the home?

- Yes
- No

If yes, please explain:

Does your child speak:

- English
- Other Language

Does your child understand:

- English
- Other Language

Which language does the child prefer to speak at home?

- English
- Other Language

Do you feel that your child has a speech-language problem?

- Yes
- No

Has your child ever had a speech-language evaluation/screening?

- Yes
- No

If yes, when and where?

What were the results?

Is your child receiving speech-language services currently?

- Yes
- No

If yes, where and for how long?

Please describe services and progress:

How does your child communicate wants or needs?

What does your child do when he/she needs help with something?

What happens if you cannot figure out what your child is asking for?

When you talk to your child, how much does he/she understand?

Does your child read?

- Yes
- No

Does your child spell?

- Yes
- No

How well is your child understood by:

Family:

- Easily
- Sometimes
- Rarely
- Never

Friends/Peers:

- Easily
- Sometimes
- Rarely
- Never

School staff or community helpers:

- Easily
- Sometimes
- Rarely
- Never

Occupational Therapy Child Self Care Addendum

List your child's skill level and add any additional comments necessary for the evaluator:

- **(D)** Dependent: parent performs the skill for the child
- **(Max)** Maximal Assistance: mostly parent, but the child attempts to help
- **(Mod)** Moderate Assistance: child is performing 50% of the skill
- **(Min)** Minimal Assistance: child is mostly performing the skill, needs a little help from parent
- **(I)** Independent: child completes independently

Activities of Daily Life	Level of Assistance					Comments
Upper Body Dressing (shirts, sweatshirts, jackets, etc.)	D	Max	Mod	Min	I	
Lower Body Dressing (pants, shorts, jeans, elastic pants, etc.)	D	Max	Mod	Min	I	
Socks	D	Max	Mod	Min	I	
Shoes	D	Max	Mod	Min	I	
Fasteners (zippers, buttons, tying shoes)	D	Max	Mod	Min	I	
Grooming (hair brushing, styling, teeth brushing, wiping face, etc.)	D	Max	Mod	Min	I	
Bathing (hair washing, body and face washing)	D	Max	Mod	Min	I	
Toileting	D	Max	Mod	Min	I	What age?
Self-feeding (using a spoon, fork, and knife)	D	Max	Mod	Min	I	
Completing self-care routines (morning routine, evening routine)	D	Max	Mod	Min	I	
Does your child have difficulty falling asleep at night?	Yes			No		
Does your child have difficulty sleeping through the night?	Yes			No		

What are some of your child's favorite toys or preferred activities?

Child Case History Vision Addendum

Ocular History

Date of last vision exam:

Doctors' office:

Visual conditions:

Does your child wear glasses? • Yes • No

If yes, for distance, reading or full-time?

Does your child wear contact lenses? • Yes • No

Do you feel that your child has a vision problem? • Yes • No

If yes, please describe:

Has your child ever had vision surgery? • Yes • No

If yes, where and when?

Reason?

Results:

Has your child ever failed a school vision screening? • Yes • No

If yes, what were the results/suggestions?

Has your child ever had treatment for amblyopia (lazy eye)? • Yes • No

If yes, what was the treatment and how long was it done for?

Did you comply with the recommended treatment?

Has your child ever had treatment for strabismus (crossed eyes)? • Yes • No

If yes, what were the results?