MIDWESTERN UNIVERSITY

THERAPY INSTITUTE
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Therapy Institute Child Case History

Client Information	Date Completed:
Child's Name:	Date of Birth:
Medical Diagnosis (if applicable):	Birth Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer to Self-Describe
Allergies:	Primary Language:
Parent/Guardian Information	
Mothers Name: (Or parent/guardian 1)	Fathers Name: (Or parent/guardian 2)
Address:	Address:
City/State/Zip:	City/State/Zip:
☐ Home Phone: ☐ Cell Phone: ☐ Work Phone:	☐ Home Phone: ☐ Cell Phone: ☐ Work Phone:
Please check the box next to the best number to reach you during the day	
Email Address:	Email Address:
Occupation:	Occupation:
☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Child lives with this parent: ☐ Yes ☐ No This parent is the preferred contact for scheduling questions: Yes ☐ No ☐	Child lives with this parent: ☐ Yes ☐ No This parent is the preferred contact for scheduling questions: Yes ☐ No ☐
Name(s) of any Siblings:	Age(s):
Status: ☐ Natural ☐ Legal Guardian ☐ Foster ☐ Other: _____	Status: ☐ Natural ☐ Legal Guardian ☐ Foster ☐ Other: _____

Outpatient Therapy History:	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?

	Age		Age
Sitting Unsupported (typical age 6 months)		Eating Finger Foods (typical age 6-9 months)	
Crawling (typical age 6-9 months)		Eating with a Spoon (typical age 18-24 months)	
First Word(s) (typical age 11 months)		Two Word Combinations (typical age 20 months)	
Walking (typical age 12-15 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 Education ☐ 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 Ed.

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?

☐ 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 the bubbles below that describe the concerns you have for your child		
Occupational Therapy	**Speech and Language**	**Visual Rehabilitation Services**
O Difficulty sitting still	O Difficulty making speech sounds	O Headaches with near work
O Sensory sensitivity (bright lights, loud noises, difficulty with grooming or the feeling of clothing)	O Difficulty understanding language/following directions	O Words run together while reading
O Social anxiety	O Difficulty putting words/sentences together	O Burning, itchy, or watery eyes
O Handwriting	O Speaks, but has a small vocabulary	O Skipping/repeating lines while reading
O Self-care skills (buttons, zippers, dressing and undressing themselves)	O Need for another method to communicate (picture book, technology, etc.)	O Tilting head or closing one eye when reading
O Tying shoes	O Stuttering	O Difficulty copying from a chalkboard
O Poor attention at school	O Feeding or swallowing difficulties	O Avoiding near work or reading
O Behaviors/meltdowns	O Voice issues	O Omitting small words when reading
O Feeding difficulties	O Other: (please describe)	O Writing uphill or downhill
O Other: (please describe)		O Misaligning digits/columns of numbers
		O Poor reading comprehension
		O Holding books or near work very close to eyes
		O Short attention span with near work
		O Difficulty completing assignments on time
		O Saying "I can't" before trying something
		O Clumsiness and knocking things over
		O Losing belongings or misplacing things
		O Forgetting things
		O Difficulty spelling
		O Excessive eye rubbing
		O Child performs better when being read to

If you checked a bubble in the above categories, please complete the corresponding addendum in the next section. 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, explain:

	English:	Other Language:
Does your child speak:	☐Yes ☐ No	☐Yes ☐ No
Does your child understand:	☐Yes ☐ No	☐Yes ☐ No
Which language does the child prefer to speak at home?	☐Yes ☐ No	☐Yes ☐ No

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 so, 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

By friends/peers: ☐ Easily ☐ Sometimes ☐ Rarely ☐Never

By school staff or community helpers: ☐ Easily ☐Sometimes ☐ Rarely ☐Never ☐ N/A

Occupational Therapy Child Self Care Addendum

List Your Child's Skill Level and 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? _____ 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 so, where and when? Reason? Results:	
Has your child ever failed a school vision screening? ☐ Yes ☐ No If so, what were the results/suggestions? Has your child ever had treatment for amblyopia (lazy eye)? ☐ Yes ☐ No If so, 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 so, what were the results?	