PEDIATRIC THERAPY CASE HISTORY

Patient Name:_____ Date:_____

What services are you seeking? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Feeding Therapy

Date of Birth: _____ Sex: ☐ Male ☐ Female

Patient: Primary Language:_____ Preferred Language:_____

Parent 1 Name:_____ Age:____ Occupation:_____

Parent 2 Name:_____ Age:____ Occupation:_____

Parent 1: Preferred Language:_____ Parent 2: Preferred Language: _____

Address:_____

Home Phone:_____ Cell Phone (Parent 1): _____ Cell phone (Parent 2):_____

Please mark which phone is your primary contact number. Person completing this form:_____

Please list names, ages of other children in the family:_____

Names of adults in the home: Please list relationship: _____

Has anyone in your family needed special education services, therapies, speech services? _____

Primary Care Physician:_____ Specialist Physicians: _____

_____

Current educational setting/support services:_____

_____

Medical/Surgical History: Please list current medical diagnoses and hospitalizations:_____

_____

Medications: list all medications your child is presently taking: _____

_____

Any allergies? ☐ Yes ☐ No If Yes, please list:_____

Birth History: Length of pregnancy: _____ Duration of Labor:_____ Delivered via: ☐ Cesarean ☐ Vaginal

Birth Weight:_____ Birth Length:_____ Please list any complications: _____

Did the child require any of the following: NICU: ☐ Yes ☐ No Special Care nursery: ☐ Yes ☐ No

Oxygen: ☐ Yes ☐ No Incubator: ☐ Yes ☐ No Other:_____

Please list age at which the child was able to do the following: Held Head up:_____ Sat without support: _____

Rolled Over: _____ Crawled: _____ Stood alone: _____ Walked independently: _____Toilet Trained: _____

Has your child had hearing screened? ☐ Yes ☐ No If Yes, what were results? _____

Has your child had vision screened? ☐ Yes ☐ No If Yes, what were results? _____

Has your child had any of the following? ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy

☐ Early Intervention ☐ Home Care ☐ Feeding Therapy

If Yes, For what condition?_____ When?_____ Where? _____

We will do our best to work with your family's schedule; however, we ask for your flexibility to find a consistent time for therapy.

Please list your availability for therapy sessions: _____

What is your preferred location for therapy services: _____

How did you hear about our services? _____

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PHYSICAL THERAPY AT St Luke's Pediatric Therapy

PEDIATRIC THERAPY CASE HISTORY

Occupational Therapy: **If you are seeking occupational therapy for your child, please complete this section.**

What are your primary concerns for an occupational therapy evaluation?_____
Play Skills: What does your child like to play with?_____
What does your child dislike playing with? _____
How would you describe your child's attention span?_____
How does your child spend free time? _____
Describe your child's social behavior with others:_____
Self Help: Has your child ever used feeding utensils? □ Yes □ No If yes, do they need help? □ Yes □ No
Please describe: _____
Can your child independently drink from a cup? □ Yes □ No
How much help does your child need to get dressed? _____
Can your child complete buttons, zipper, snaps? □ Yes □ No
Sensory: Do you have any concerns with your child's sensory processing?_____
_____

Physical Therapy: **If you are seeking physical therapy for your child, please complete this section.**

What are your primary concerns for a physical therapy evaluation? _____
Has your child ever used braces or orthotics?_____
Has your child ever used any specialized equipment? _____
Has your child seen an orthopedic doctor? □ Yes □ No
If Yes, Who?_____ When?_____ Why? _____
Has your child had any imaging (i.e., CT scan, MRI, X-ray, Ultrasound)?_____

Speech-Language Therapy: **If you are seeking speech therapy for your child, please complete this section.**

What are your primary concerns for a speech-language evaluation?_____
Hearing: Has your child had a full hearing evaluation?□ Yes □ No If yes, please describe:_____
Does your child respond to soft or moderate sounds? □ Yes □ No
Does your child seem to listen to people's voices? □ Yes □ No
Can your child follow instructions which are expected for his/her age? □ Yes □ No
Does your child like to listen to children's stories? □ Yes □ No
Speech and Language: Please provide age at which started and example for the follow categories:

Babbling:	Age: _____	Example: _____
First words:	Age: _____	Example: _____
Put 2 words together:	Age: _____	Example: _____
Put 3-4 words together:	Age: _____	Example: _____
Sentences:	Age: _____	Example: _____

Has your child's speech progress ever been interrupted or reversed? □ Yes □ No
If Yes, please describe: _____
When was the problem with speech/language first noticed?_____
Did it follow an illness, accident or unusual occurrence?_____
Is your child's speech understood by family? □ Yes □ No People outside of the family? □ Yes □ No

Parent Signature:_____ Date: _____

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