TheraKids INC.
Specializing in Pediatric Speech, Language, Feeding and Swallowing

Case History for Pre-School-Aged Children

Date: _____

Child's Name: _____ Date of Birth: _____

Parents' / Legal Guardians' Names: _____

Home Address: _____ Home Phone: (_____)_____
_____ Cell Phone: (_____)_____
County: _____ Work Phone: (_____)_____
Email Address: _____
Would you like to be contacted via text / e-mail regarding your child's therapy schedule? **Yes** **No**

Child's Primary Doctor/Pediatrician : _____
Address/Phone: _____

Reason for Visit: _____
_____
_____
_____

When did you first notice this problem(s)? _____

Language(s) spoken in the home: _____

Pregnancy, Labor and Delivery

1. List any problems or complications during pregnancy (i.e.: gestational diabetes, eclampsia, maternal seizures, accidents/injuries, etc.):
   _____
   _____

2. List all medications/drugs taken during pregnancy (i.e.: prenatal vitamins, medications for high blood pressure, medications for seizures, cocaine, heroin, etc.):
   _____
   _____

3. List any problems or complications during labor and/or delivery (i.e.: cord wrapped around neck, breech delivery, anoxia/"blue" at birth, respiratory distress, etc.):
   _____
   _____

4. List any medical conditions/illnesses your child was diagnosed with (i.e.: cerebral palsy, Down syndrome, etc.): _____
   _____

5. List any problems or complications your child had after birth (i.e.: poor feeder, respiratory distress, seizures, etc.): _____
   _____

Developmental and Medical History

6. How old was your child when he/she:

Sat alone: _____	Babbled: _____
Stood: _____	Used first words: _____
Crawled: _____	Combined words: _____
Walked alone: _____	Used sentences: _____

7. Currently, what is your child's main way he/she communicates?

____Crying/Whining _____2 & 3 word phrases ____ Making noises
____Complete sentences _____Gesturing/Pointing ____Single words
If less than 10 words, please list_____

8. Is your child easily understood by:

You?	YES	NO
Other family members?	YES	NO
People outside the home?	YES	NO

9. Check all below that your child has a history of:

___ High fevers ___ Ear infections ___ Seizures ___ Mouth breathing ____Frequent colds
___ Hoarseness ___Allergies: ___ Swallowing problems ___ Feeding problems
Other: _____

10. List any accidents / injuries / surgeries and their dates:

_____ _____
_____ _____
_____ _____

11. List all medications your child currently takes:

Medication	Dose (i.e.: mg)	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Has your child ever had his/her hearing tested? NO YES If yes:
Date:_____
Results:_____
Does your child have problems with his/her hearing? If yes, please explain:
_____

13. Has your child had any previous testing?

			Date	Results
MRI	NO	YES	_____	_____
CT	NO	YES	_____	_____
EEG	NO	YES	_____	_____
Developmental/Educational	NO	YES	_____	_____
Psychological/Psychiatric	NO	YES	_____	_____
Neurological	NO	YES	_____	_____

Family History

14. Past family history of: (please check) Who?

___Late talking _____
___Speech problems _____
___Language problems _____
___Intellectual disabilities _____
___Learning disabilities _____
___Psychological/psychiatric problems _____
___Neurological problems _____
___Genetic disorders _____
___Hearing problems _____
___Other _____

15. List all people living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Circle parents' level of education:
    Mother: Grade school High school College 5+
    Father: Grade school High school College 5+
17. Mother's current occupation/job: _____
18. Father's current occupation/job: _____

19. Does your child attend daycare or preschool? NO YES, _____ hours weekly
    Setting:
    ___ In-home daycare: How many children attend? ____ How many children his/her age? ____
    ___ Private daycare center: How many children in his/her "group?" ____
    Name of the center: _____
    ___ Pre-K through the public school system: How many children are in the class? ____
    Name of the center: _____
    ___ Headstart: How many children are in the class? ____
    Name of the center: _____

20. With whom does your child spend his/her days? _____
21. What does your child do during the day? _____

22. **General Statements and Questions Regarding Your Child (Please check all that apply):**

During playtime my child:
- _____ Does not seem very interested in toys.
- _____ Explores toys.
- _____ Typically plays with other children.
- _____ Tends to play by him/herself.
- _____ Shares toys.
- _____ Takes turns.
- _____ What is his/her favorite toy or activity?_____
- _____ Other:_____

During the nighttime my child:
- _____ Sleeps well throughout the entire night.
- _____ Wakes up once in a while, but easily goes back to sleep.
- _____ Tends to wake up 1-3 times per night, and requires attention.
- _____ Sleeps some, but requires some sort of food/drink during the night.
- _____ Sleeps some, but typically plays in the middle of the night.
- _____ Other:_____

During mealtimes my child:
- _____ Eats all of his/her food without any difficulties.
- _____ Tends to be a picky eater.
- _____ Drinks from a bottle.
- _____ Drinks from a sippee cup.
- _____ Drinks from a regular cup with assistance.
- _____ Drinks from a regular cup by self.
- _____ Stays in his/her seat during meals.
- _____ Does not sit still for meals.
- _____ Other:_____

Regarding potty training my child is:
- _____ Fully trained.
- _____ Says when he/she needs to use the bathroom, but not fully trained.
- _____ Indicates when his/her diaper is wet or dirty, but not fully trained.
- _____ Seems interested in potty training, but not fully trained.
- _____ Shows no interest in potty training.
- _____ Other:_____

Regarding my child's attention:

_____ He/She seems to attend to me and most activities 80-100% of the time.
_____ He/She seems to attend to me and most activities 50-75% of the time.
_____ He/She doesn't attend to me but stays focused during other activities.
_____ He/She has difficulty attending at all times.
_____ His/Her average attending time to books and toys is_____
_____ Other:_____

Regarding my child's memory:

_____ He/She tends to remember 2-3 step directions.
_____ He/She tends to remember only one step directions.
_____ He/She does not follow through with any directions.
_____ He/She tends to ask for directions to be repeated.
_____ Other:_____

Feeding History

23. Was/is your child breast fed? NO YES If yes, for how long? _____
Is he/she still breast fed? NO YES If no, when did he/she stop? _____
Reason for stopping: _____
Problems/Difficulties: _____

24. Was/is your child bottle fed? NO YES If yes, for how long? _____
Is he/she still bottle fed? NO YES If no, when did he/she stop?
_____
Reason for stopping: _____
Problems/Difficulties: _____

Nipples tried: (circle all that apply)	Problems/Difficulties?		If yes, Please describe:
____ Straight latex	YES	NO	_____
____ Straight silicone	YES	NO	_____
____ NUK latex	YES	NO	_____
____ NUK silicone	YES	NO	_____
____ Slow flow	YES	NO	_____
____ Medium flow	YES	NO	_____
____ Fast flow	YES	NO	_____
____ Gerber	YES	NO	_____
____ Playtex nurser	YES	NO	_____
____ Other: _____			

Current nipple: (circle)	Problems/Difficulties?		If yes, Please describe:
____ Straight latex	YES	NO	_____
____ Straight silicone	YES	NO	_____
____ NUK latex	YES	NO	_____
____ NUK silicone	YES	NO	_____
____ Slow flow	YES	NO	_____
____ Medium flow	YES	NO	_____
____ Fast flow	YES	NO	_____
____ Gerber	YES	NO	_____
____ Playtex nurser	YES	NO	_____
____ Other: _____			

25. Does/did your child drink from a cup? NO YES If yes, what type?
____ Regular ____ Sippy ____ Straw ____ Spill-proof valve ____ Other_____
Problems/Difficulties: _____

26. Please list types of food/drink your child currently eats/drinks during mealtimes:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

27. Foods that have been or are currently eaten:

	Problems/Difficulties?		If yes, please describe:	Do they continue to eat these foods?	
____ Formula	YES	NO	_____	YES	NO
____ Pediasure	YES	NO	_____	YES	NO
____ Stage 1 foods	YES	NO	_____	YES	NO
____ Stage 2 foods	YES	NO	_____	YES	NO
____ Stage 3 foods	YES	NO	_____	YES	NO
____ Graduate meals	YES	NO	_____	YES	NO
____ Soft finger foods	YES	NO	_____	YES	NO
____ Crunchy finger foods	YES	NO	_____	YES	NO
____ Blenderized foods	YES	NO	_____	YES	NO
____ Mashed table foods	YES	NO	_____	YES	NO
____ Soft table foods	YES	NO	_____	YES	NO
____ Regular table foods	YES	NO	_____	YES	NO

28. Is your child currently meeting his/her caloric needs? (please circle) YES NO

29. Childs current caloric intake is _____, but should be _____.

30. Has your child ever been fed by: NO YES If yes, when and for how long?

____ OG Tube _____
____ NG Tube _____
____ NJ Tube _____
____ GJ Tube _____
____ G- Tube _____

Current tube feeds: Since when?

____ OG Tube _____
____ NG Tube _____
____ NJ Tube _____
____ GJ Tube _____
____ G- Tube _____

31. Current feedings: (fill in all that apply)

Gravity ____ cc's over ____ minutes ____ x/day (times: _____)
Bolus ____ cc's _____ cc/hr x ____ hours ____ x/day (times: _____)
Drip ____ cc/hr x _____ hours Between _____ AM/PM to _____ AM/PM
Oral ____ meals/day Between _____ AM/PM to _____ AM/PM

"Meals" (circle all that apply)

Formula Baby food Blenderized table foods Mashed table foods
Soft, bite sized table foods Regular table food Other: _____

32. Food allergies: _____
_____

Intervention/Therapy History

33. List all special education/therapy services your child is **CURRENTLY** receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

34. List all other special education/therapy services your child has **RECEIVED IN THE PAST**, but is no longer receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

35. Has your child made progress in previous feeding therapy? YES NO
Please explain: _____
_____

36. Check all the areas below in which you feel your child has difficulties:

_____ Sounding out words	_____ Reading comprehension	_____ Writing
_____ Math computation	_____ Math word problems	_____ Following directions
_____ Other: _____		

37. Describe your child's reactions to his/her difficulties:

_____
_____

38. Check all below that describe your child:

____ Makes friends easily	____ Nervous/anxious	____ Generally cooperative
____ Disruptive	____ Loner	____ Keeps friends
____ Cries easily	____ Frustrated	____ Has temper tantrums
____ Likes school	____ Dislikes school	____ Generally happy
____ Generally unhappy	____ Other: _____	

Please list any other information you feel is important for us to know:

_____
_____
_____
_____
_____
_____

RELEASE OF INFORMATION

I hereby authorize TheraKids, Inc. to release and/or receive information regarding my child:

Patient's Name: _____ DOB: _____

To doctors, schools, and/or agencies listed below:

_____
_____
_____
_____

Information to be released/received includes:

_____
_____
_____
_____

Parent's/Legal Guardian Signature: _____ Date:_____

Along with this history form you were given a packet of information. Please sign below as confirmation that you were given this packet.

I, (print name)_____, have received and read the following documents, and they were explained to me, as needed: *Notice of Privacy Practices, as required by HIPAA; Letter of introduction to TheraKids, Inc.; and Attendance Policy for TheraKids, Inc.*

_____ _____

Signature/Relation to patient **Date**

THANK YOU FOR YOUR CAREFUL ATTENTION TO THIS FORM.
This confidential information will be used to assist us in the evaluation of your child.