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

Case History for School-Aged Children

Date: _____

Child's Name: _____ Date of Birth: _____

Parents' / Legal Guardians' Names: _____
(circle one)

Home Address: _____ Home Phone: (_____)_____
_____ Cell Phone: (_____)_____
County: _____ Work Phone: (_____)_____
Email Address: _____

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	_____	_____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Educational History

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. List the name of the school your child currently attends:_____
    Address: _____ Phone: (____)_____
    _____ Fax: (____)_____

20. List your child's current grade in school: _____

21. Has your child ever been retained or repeated a grade? NO YES- If yes, which grade(s)? _____

22. What is your child's current school placement?
    _____ Regular classroom _____ ESE (Exceptional student education)

    If he/she is in an ESE program, please check all that apply below:
    ____ Full time ____ Part time ____ Self contained ____ Pull out

    ____ LD (Learning disabled) ____ VE (Varying exceptionalities)
    ____ EMH (Educable mentally handicapped) ____ TMH (Trainable mentally handicapped)
    ____ SLI (Specific language impaired) ____ PI (Physically impaired)
    ____ HI (Hearing impaired) ____ EH (Emotionally handicapped)
    ____ Other: _____

23. 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)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

24. 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)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

25. 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: _____

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

27. 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.