KIDSENSE THERAPY GROUP
CLIENT GENERAL CASE HISTORY

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

BACKGROUND & FAMILY INFORMATION

Child's Name _____

Date of Birth /Age _____ /_____ Gender: ☐ Male ☐ Female ☐ Non-binary

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian Name _____ Occupation _____

Parent/Guardian Name _____ Occupation _____

Siblings (Names and Ages) _____

Where/Who does child live with _____

Primary Phone _____ May we leave a message? ☐ Yes ☐ No

Alternate Phone _____ May we leave a message? ☐ Yes ☐ No

E-mail _____ May we email you? ☐ Yes ☐ No

Pediatrician's Name _____ Phone Number _____

Pediatrician's Address _____

Referred by _____

Briefly describe primary reason for seeking therapy:

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes:

Which language(s): _____

What language(s) does the child use/speak? _____

What language(s) does the child understand? _____

What percentage of the child's day would you estimate they are exposed/using each language?

Language 1: _____ Language 2: _____

How would you rate your child's proficiency in each language? (check)

Language 1: ☐ Limited ☐ basic ☐ intermediate ☐ advanced ☐ native like

Language 2: ☐ Limited ☐ basic ☐ intermediate ☐ advanced ☐ native like

Are you aware of any learning difficulties in the child's native language? ☐ Yes ☐ No

Explain:

EARLY HEALTH/DEVELOPMENTAL HISTORY

Prenatal and Birth History

Length of Pregnancy _____ Length of Labor _____

Were there any complications during pregnancy? ☐ Yes ☐ No (i.e. high blood pressure, gestational diabetes, exposure to drugs/alcohol)

Explain:

General Condition of Mother during Labor _____

Type of Delivery _____ Birth Weight _____

General condition of your child during/after delivery (any special interventions etc.):

Please add any other information related to the pregnancy/labor/birth than may be pertinent to your child's therapy.

Developmental History

Provide the approximate time (in months/years) at which your child began to perform the following activities or write N/A if not yet attained.

Rolling over_____ Sitting Unsupported_____ Crawling_____ Walking Alone_____ Finger Feed_____

Feed self w/utensils _____ Cup drink _____ Drink w/straw _____ Toilet Trained: Daytime _____/Nighttime_____

Sleep through the night _____ Running _____ Skipping _____ Riding tricycle/bicycle _____

Hand Dominance _____ Tie Shoes _____ Using Words (single)_____ (combine 2 words)_____

Name Simple Objects_____ Use Simple Questions _____ Speak in Sentences _____ Engage in Conversation_____

Does your child have any feeding difficulties (sucking, swallowing, drooling, chewing) ☐ currently? ☐ In the past?

If so, please describe:

How does your child usually communicate? ☐ gestures ☐simple words ☐ short phrases ☐ sentences

Does your child use speech meaningfully? ☐ Yes ☐ No

Can you (parent/guardian) understand your child's speech? ☐ Yes ☐ No

Can playmates, teachers, and relatives understand your child's speech? ☐ Yes ☐ No

Is your child aware of any difficulties they may be experiencing? ☐ Yes ☐ No

Does your child currently ☐ use a pacifier and/or ☐ suck their thumb?

Has your child ☐ used a pacifier and/or ☐ sucked their thumb in the past? If so, for how long? _____

Is there any history of speech, language, or hearing problems in your family? ☐ Yes ☐ No

If yes, please describe:

Describe your child's response to sound:

Can your child ☐ color ☐ write ☐ draw ☐ paint?

Does your child seem ☐ weak and/or ☐ get tired easily?

Does your child ☐ enjoy movement (playground, cars, bikes) and/or ☐ prefer sitting activities?

Does your child ☐ lose their balance, ☐ crash a lot, and/or ☐ fall down on purpose?

Does your child ☐ avoid certain clothing textures and/or are ☐ bothered by tags/seams in socks?

Does your child exhibit any difficulties with self-care such as ☐ dressing ☐ self-feeding ☐ grooming and/or ☐ bath time?

Does your child exhibit any difficulties regarding gross or fine motor skills, including:

☐ walking ☐ running ☐ playing on playground ☐ coloring ☐ manipulating toys

☐ fasteners (zippers, buttons, tying shoes) and/or ☐ participating in other activities which require small or large muscle coordination?

How does your child walk, crawl, sit and move from floor to standing?

Does your child appear to have ☐ tight muscles ☐ loose muscles or ☐ seem very flexible?

Receptive Language Development (Understanding Language): Check all that apply

- ☐ Processes information within an appropriate amount of time
- ☐ Understands new concepts easily, incorporates new vocabulary into communication
- ☐ Learns new concepts with repetition, needs cues to use new vocabulary. Visual and physical cues helpful
- ☐ Delay in response time
- ☐ Understands communication when paired with visual and physical prompts
- ☐ Very concrete comprehension
- ☐ Child has difficulty understanding the concepts and language introduced- requires visual and/or physical prompts to understand message

Expressive Language Development (Use of Language): Check one

- ☐ Advanced vocabulary, sentence structure and communication skills
- ☐ Age expected vocabulary, sentence structure and communication skills
- ☐ Slightly delayed vocabulary, sentence structure and communication skills
- ☐ Significantly delayed vocabulary, sentence structure and communication skills

Medical History

Where does the child receive their regular medical care?

_____

Does your physician have any concerns about your child's nutritional status? ☐ Yes ☐ No

Explain:

Does your child have a diagnostic label (i.e. birth defect, genetic disorder, developmental delay): ☐ Yes ☐ No

List here: _____

Has your child's hearing been tested? ☐ Yes ☐ No

If so, what are the results? _____

Does your child have a history of middle ear infections? ☐ Yes ☐ No

If so, include when and how often. Has he/she required ear surgery?

Has your child had any other surgeries/accidents/hospitalizations? ☐ Yes ☐ No

If so, please describe reason/age of onset?

Does your child exhibit any of the following illnesses or conditions? Check all that apply and explain below.

☐Allergies (seasonal or food) ☐Asthma ☐Seizures ☐Vision Problems ☐Lead Poisoning ☐Head Injuries ☐Frequent Colds
☐Kidney Issues ☐Upper Respiratory Disorder ☐ Urinary Issues ☐Heart Condition ☐Constipation ☐Frequent Strep Throat
☐Failure to Thrive ☐Reflux ☐Diarrhea ☐Gastrointestinal Issues ☐Epi-pen ☐ Teeth grinding ☐ Snoring ☐ Mouth breathing
☐ Tension in the jaw

Is your child currently taking any psychiatric or prescription medications? ☐ Yes ☐ No

If so, please list.

Has your child ever been evaluated by any specialists? ☐ Yes ☐ No

Explain:

Has your child received any therapy (including Birth-Three, speech/language, occupational, physical, ABA, etc.) in the past? ☐ Yes ☐ No

If so what type, when and where? Please give a brief summary of results.

Social/Emotional/Behavioral History

Describe the child's personality (check all that apply): ☐Happy ☐Sad ☐Outgoing ☐Timid ☐Sensitive to criticism ☐Confident ☐Moody ☐Friendly ☐Quiet ☐Talkative ☐Fearful ☐Nervous ☐Affectionate ☐Withdrawn ☐Bossy ☐Easy going ☐Independent ☐Overly dependent ☐Irritable ☐Angry ☐Well-liked ☐Funny ☐Silly

List or describe your child's strengths and positive characteristics:

Please list all organized peer group activities (i.e. hobbies, sports) in which your child participates (include frequency):

Please list your child's special interests and/or talents:

How does your child respond to changes in routine?

How does your child handle new people/new environments/uncomfortable situations?

How does your child handle unstructured time (i.e. playground, recess)?

Does your child seem flexible or do they struggle with changes/have difficulty with transitions?

Does your child engage in any self-soothing behaviors that are of concern or not developmentally appropriate, including:

☐ rocking ☐flapping ☐thumb sucking ☐ objects that they cannot put down or leave the house without?

Explain:

Have there been any major changes in the home recently (separation of parents, moving, family members passing away)? ☐Yes ☐No

Explain:

How does your child interact with peers? _____

How does your child interact with adults? _____

How well does your child make social plans (include how often and how he/she interacts with peers)?

_____

Describe your child's attitude towards school/household tasks.

Will your child seek help from a peer, teacher, and/or relative? ☐ Yes ☐ No

How does your child respond to adult reminders/redirection to complete tasks?

Briefly describe any difficulties in raising your child and, if applicable, how has this impacted you or your family?

Behaviors (check all that apply): ☐Frequent crying ☐ Motivated ☐ Anxious ☐ Aloof/internally distracted ☐Externally distracted
☐ Impulsive ☐Oppositional ☐ Difficulty separating ☐ Withdrawal from others ☐Overactivity ☐Physically aggressive
☐ Verbally aggressive ☐ Rigid ☐ Withdrawn ☐ Temper tantrums ☐Destructiveness ☐Tics ☐Nail biting ☐Excessive blinking
☐ Rocking ☐ Thumb sucking ☐ Hair pulling ☐ Daydreaming ☐Bedwetting ☐Lying ☐Stealing ☐Alcohol/drug use
☐ Legal issues/involvement ☐ Gang involvement ☐Sexual activity

Do you have any community organizations involved with your family (i.e. DCF, Probation): ☐ Yes ☐ No

Explain:

Educational History

Where does your child currently attend school? _____

Teacher _____ Grade _____

Does your child attend any before/after school program(s)/activities? ☐ Yes ☐ No

If yes, please describe.

Does your child exhibit any academic difficulties? ☐ Yes ☐ No

If so, please explain.

Does your child attend school regularly? ☐ Yes ☐ No

If no, please explain.

Are there any attendance concerns ☐ currently or ☐ historically?

If so, please describe when and the reason. _____

Has your child had any interdisciplinary incidents? ☐ Yes ☐ No

If so, please describe when and the reason. _____

Has your child ever been retained? ☐ Yes ☐ No

If so, what grade and school? _____

Has your child received any extra support in/outside of school? ☐ Yes ☐ No

If so, please explain. _____

Does your child receive any Tier II and/or Tier III Interventions for academic/behavioral support? ☐ Yes ☐ No

If so, please explain.

Has your child ever been tested for special education services before? ☐ Yes ☐ No

If so, when and what was the outcome?

Does your child have an Individualized Educational Plan (IEP) or 504 Plan for school? ☐ Yes ☐ No

If so, please briefly explain what it addresses.

What does your child enjoy most about school? Favorite subject?

Does your child have friends at school? ☐ Yes ☐ No

Any additional information pertinent to your child's school history? ☐ Yes ☐ No

KIDSENSE THERAPY GROUP
CLIENT GENERAL CASE HISTORY

Concerns: Please check all areas that are a concern.

Academics: ☐ reading ☐ writing ☐ math skills ☐ organization (school materials)

Self-Care: ☐ Eating/feeding ☐ hygiene (bathing, dressing, oral care, hair care) ☐ getting ready for school and sleeping

Social/Emotional Development: ☐ emotional regulation ☐ fears ☐ coping skills ☐ attention

☐ making friends ☐ problem solving

Communication: ☐ understanding directions ☐ understands vocabulary ☐ understands conversation

☐ understands nonverbal language (gestures/facial expressions) ☐ comprehending conversations/stories

☐ understands academic instruction ☐ expressing self clearly and concisely

☐ using appropriate vocabulary/grammar ☐ using appropriate speech clarity ☐ using appropriate voice ☐ using appropriate fluency

Motor: ☐ walking ☐ running ☐ jumping ☐ balance ☐ posture ☐ endurance ☐ writing ☐ drawing

Sensory: ☐ sitting still when expected ☐ overly seeking movement ☐ able to handle transitions well

☐ sensitivities to sounds/clothes/textures and/or visual stimulation.

How long have you had these concerns? _____

Any significant factors that may have contributed to the concern? ☐ Yes ☐ No

If so, please explain.

What are your goals/expectations for therapy?

Person completing form: _____

Relationship to client: _____ Date: _____

KIDSENSE THERAPY GROUP
ALLERGY ALERT FORM

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Child's Name: _____

Primary Emergency Contact (Name/Phone #):

_____

Full Name *Telephone Number*

Secondary Emergency Contact (Name/Phone #):

_____

Full Name *Telephone Number*

Does the client have any known allergies (i.e. to foods, medicines, environmental agents)? If so, please list each allergen and describe the client's response to contact with the allergen(s).

Please describe immediate action to be taken in case of contact with allergen(s).

Person completing form: _____

Relationship to client: _____ Date: _____

KIDSENSE THERAPY GROUP
CREDIT CARD AUTHORIZATION

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Child's Name: _____

AUTHORIZATION TO BILL CREDIT CARD FOR SERVICES

I _____, authorize KidSense Therapy Group to bill my credit card for therapeutic services rendered. I understand that my credit card will be automatically billed on the day services are completed, or the day session installments are indicated (for groups) for my co-pay and/or out-of-pocket charge amount. I understand that I have the right to cancel this automatic payment option at any time with a written request provided to KidSense Therapy Group. The automatic billing will terminate upon the discharge of services and/or once the amount owed is paid in full.

My credit card information is as follows:

Name as it Appears on Card:_____

Type of Credit Card (please check):

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐ FSA/HSA

Credit Card #: _____

Exp. Date: _____

Billing Address:

_____

_____

_____

Person completing form: _____

Relationship to client: _____ Date: _____

KIDSENSE THERAPY GROUP
INSURANCE FORM

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Client's Last Name_____ First Name _____ Middle Initial _____

D.O.B (MM/DD/YYYY) _____ ☐ Male ☐ Female ☐ Non-binary

Address _____ City _____ State_____ Zip _____

Main Phone #: _____ Alternative Phone # _____

PHYSICIAN INFORMATION

Name of Pediatrician or PCP _____ Phone # _____

(first) (last)

PRIMARY POLICY HOLDER INFORMATION

Insurance Company _____ Client's ID # _____ Group # _____

Primary Member Name_____ Primary Member D.O.B _____

☐ Address Same as Client Relationship to Client_____

Address _____ City _____ State_____ Zip _____

Primary Phone # : _____

SECONDARY POLICY HOLDER INFORMATION

Do you have any additional insurance? ☐ **Yes** ☐ **No** **If yes, please complete the following**:

Insurance Company _____ Client's ID # _____ Group # _____

Primary Member Name_____ Primary Member D.O.B _____

☐ Address Same as Client Relationship to Client _____

Address _____ City _____ State_____ Zip _____

Primary Phone # : _____

RELEASE OF INFORMATION

I authorize release of any information concerning my/ my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to KidSense. I acknowledge and accept responsibility for any financial obligations that the insurance company does not ultimately cover.

Signature of Responsible Party: _____Date: _____