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

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**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: _____