

# General Cast History ST/OT/PT - Sans Consent Forms - English

---

## CLIENT GENERAL CASE HISTORY

### 1. Client information:

Client's First Name:	Client's Middle Name:	Client's Last Name:	
_____	_____	_____	
Date of Birth:	Gender:	Street Address:	Apt./Unit #:
_____	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Non-binary	_____	_____
City:	State:	Zip Code:	
_____	_____	_____	
How Did You hear About Us / Referred By:	Your Preferred Service Location:		
_____	<input type="checkbox"/> 209 Cherry St, Milford, CT <input type="checkbox"/> 29 Federal Rd. Danbury, CT		

### 2. Please include any accommodations/accessibility needs for the client or family member here:

\_\_\_\_\_

### 3. Physician Information

Name of Pediatrician or PCP:	Pediatrician Group	
_____	_____	
Phone:	Street Address:	Apt./Unit #:
_____	_____	_____
City:	State:	Zip Code:
_____	_____	_____

## INSURANCE FORM

### 4. PRIMARY MEMBER/POLICY HOLDER INFORMATION

Primary Insurance Company:	Member ID / Policy #:	Group Number:
_____	_____	_____
Client Relationship to Insured:		
<input type="radio"/> Parent <input type="radio"/> Guardian <input type="radio"/> Client/Self		
Policy Holder's Name:	Policy Holder's Date of Birth:	
_____	_____	

**5. Do you have additional/secondary insurance?**

- Yes
- No

**6. SECONDARY POLICY HOLDER INFORMATION**

Do you have any additional insurance?

If yes, please complete the following:

- Yes  No

Secondary Insurance Company: \_\_\_\_\_ Member ID / Policy #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Client Relationship to Insured:

- Parent  Guardian  Patient/Self

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Phone #: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Gender:  Female  Male

Policy Holder's Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Holder's Employer/School: \_\_\_\_\_

**7. Please provide images of your insurance card(s), front and back.**

## ALLERGY ALERT FORM

**8. Please list any known allergies the client may have (i.e. to foods, medicines, environmental agents) and describe the client's response to contact with the applicable allergen(s).**

	Allergic to?	Reaction
1		
2		
3		

**9. Primary Emergency Contact**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_

**10. Secondary Emergency Contact**

Name:

Phone:

Emergency Contact Relationship:

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

Four horizontal lines for text entry.

## BACKGROUND & FAMILY INFORMATION

12. Parent/Guardian information:

Parent/Guardian Name:

Occupation:

Parent/Guardian Name:

Occupation:

13. Where/Who does the child live with:

One horizontal line for text entry.

14. Does the Client have any siblings?

- Yes
 No

15. Siblings

Table with 3 columns: Index, Name, Age. Rows 1, 2, 3.

16. Primary Contact Information

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

**17. OPTIONAL: RELEASE OF INFORMATION** I hereby give my authorization for the staff of KidSense Therapy Group to **PROVIDE** information regarding my child, to the following people/professionals. (Example: Child's Referring Primary Care Physician).

	Name	Phone	Authorization given starting from this Date:
1			

**18. OPTIONAL: GATHERING OF INFORMATION** I hereby give my authorization for the staff of KidSense Therapy Group to **GATHER** information regarding my child, from the following people/professionals. (Example: Lactation Consultant or Child' Orthodontist)

	Name	Phone	Authorization given starting from this Date:
1			

**19. Please select the modality most closely related to your child's case history. You may be prompted to complete supplemental questions related to your selection here.**

- Occupational Therapy       Speech Language Therapy       Physical Therapy

**20. Marketing Opt in:**

Yes, please send me email message notifications of upcoming events, promotions, and news from KidSense Therapy Group.

- Yes, opt me in!    No thank you

Electronic Documentation: I consent to receive unencrypted electronic documentation

- Yes, I agree    No, I do not agree

Release of Photo/Video Agreement: I hereby give my permission for my child to have pictures/videos taken when participating in therapies at KidSense Therapy Group. These pictures/videos may be used for the following purposes (please check the boxes for those that you give permission for):

- Future staff training materials to be kept in-house    Brochures and other print promotional materials  
 Website (internet) promotions and social media posting    Slideshows to be shown at fairs

**21. Briefly describe primary reason for seeking therapy:**

---

---

---

---

**22. Are there any other languages spoken at home other than English?**

- Yes  
 No

**23. If yes:**

Which language(s):

---

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

What language(s) does the child understand?

If applicable, please describe any learning difficulties in the child's native language (please specify language):

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

Language 1:

Language 2:

25. How would you rate your child's proficiency in each language?

Language 1:

Limited  basic  intermediate  advanced  native like

Language 2:

Limited  basic  intermediate  advanced  native like

## EARLY HEALTH/DEVELOPMENTAL HISTORY

### Prenatal and Birth History

26. Length of Pregnancy:

Length of Labor:

27. Were there any complications during pregnancy? (i.e. high blood pressure, gestational diabetes, exposure to drugs/alcohol)

Yes

No

If yes, please explain:

28. General Condition of Mother during Labor:

Type of Delivery:

Birth Weight:

29. Please describe the general condition of your child during/after delivery (any special interventions etc.):

---

---

---

---

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

---

---

---

---

## Developmental History

31. 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:	Feed self w/utensils:	Cup drink:
_____	_____	_____	_____
Sleep through the night:	Running:	Hand Dominance:	Tie Shoes:
_____	_____	_____	_____
Name Simple Objects:	Crawling:	Drink w/straw:	Skipping:
_____	_____	_____	_____
Using Words (single):	Use Simple Questions:	Walking Alone:	Finger Feed:
_____	_____	_____	_____
Toilet Trained: Daytime	Toilet Trained: Nighttime	Riding tricycle/bicycle:	Combine 2 words:
_____	_____	_____	_____
Speak in Sentences:	Engage in Conversation:		
_____	_____		

32. Does your child have any feeding difficulties (sucking, swallowing, drooling, chewing) currently?

- Currently                       In the past

If so, please describe:

---

33. How does your child usually communicate?

- gestures                       simple words                       short phrases  
 sentences

34. Does your child use speech meaningfully?

- Yes
- No

35. Can you (parent/guardian) understand your child's speech?

- Yes
- No

36. Can playmates, teachers, and relatives understand your child's speech?

- Yes
- No

37. Is your child aware of any difficulties they may be experiencing?

- Yes
- No

38. Does your child currently

- use a pacifier
- suck their thumb

39. Has your child used

- use a pacifier
- suck their thumb in the past

If so, for how long?

---

40. Is there any history of speech, language, or hearing problems in your family?

- Yes
- No

If yes, please describe:

---

41. Describe your child's response to sound:

---

---

---

---

42. Can your child

- color
- write
- draw
- paint

**43. Does your child seem**

- weak  get tired easily

**44. Does your child**

- enjoy movement (playground, cars, bikes)  prefer sitting activities

**45. Does your child**

- lose their balance  crash a lot  fall down on purpose

**46. Does your child**

- avoid certain clothing textures socks  bothered by tags/seams in

**47. Does your child exhibit any difficulties with self-care such as**

- dressing  self-feeding  grooming  
 bath time

**48. 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)  
 participating in other activities which require small or large muscle coordination

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

---

---

---

---

**50. Does your child appear to have**

- tight muscles  loose muscles  seem very flexible



**51. 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

**52. 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

**53. Does your physician have any concerns about your child's nutritional status?**

- Yes
- No

If so, please explain:

---

**54. Does your child have a diagnostic label (i.e. birth defect, genetic disorder, developmental delay):**

- Yes
- No

If so, list here:

---

**55. Has your child's hearing been tested?**

- Yes
- No

If so, what are the results?

---

56. 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?

---

57. Has your child had any other surgeries/accidents/hospitalizations?

- Yes
- No

If so, please describe reason/age of onset?

---

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

	Yes	Explain
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		
Tension in the jaw		
Reflux		
Diarrhea		
Gastrointestinal Issues		
Teeth grinding		
Snoring		
Mouth breathing		

59. Is your child currently taking any psychiatric or prescription medications?

- Yes
- No

60. If so, please list.

	Medication	Dosage	Frequency	Reason for taking
1				
2				
3				

61. Has your child ever been evaluated by any specialists?

- Yes
- No

If so, please explain:

---

62. 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

63. Describe the child's personality (check all that apply):

- |                                       |   |                                    |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Happy        | <input type="checkbox"/> Sad                    | <input type="checkbox"/> Outgoing  |
| <input type="checkbox"/> Timid        | <input type="checkbox"/> Sensitive to criticism | <input type="checkbox"/> Confident |
| <input type="checkbox"/> Well-liked   | <input type="checkbox"/> Friendly               | <input type="checkbox"/> Funny     |
| <input type="checkbox"/> Moody        | <input type="checkbox"/> Silly                  | <input type="checkbox"/> Quiet     |
| <input type="checkbox"/> Talkative    | <input type="checkbox"/> Fearful                | <input type="checkbox"/> Nervous   |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Withdrawn              | <input type="checkbox"/> Angry     |
| <input type="checkbox"/> Bossy        | <input type="checkbox"/> Easy going             | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Independent  | <input type="checkbox"/> Overly dependent       |                                    |

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

---

---

---

---

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

---

---

---

---

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

---

---

---

---

67. How does your child respond to changes in routine?

---

---

---

---

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

---

---

---

---

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

---

---

---

---

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

---

---

---

---

71. 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?

If so, please explain:

---

72. Have there been any major changes in the home recently (separation of parents, moving, family members passing away)?

- Yes
- No

If so, please explain:

---

73. How does your child interact with peers?

---

74. How does your child interact with adults?

---

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

---

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

---

---

---

---

77. Will your child seek help from a peer, teacher, and/or relative?

- Yes
- No

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

---

---

---

---

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

---

---

---

---

80. Behaviors (check all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Frequent crying             | <input type="checkbox"/> Motivated             | <input type="checkbox"/> Anxious                |
| <input type="checkbox"/> Aloof/internally distracted | <input type="checkbox"/> Externally distracted | <input type="checkbox"/> Impulsive              |
| <input type="checkbox"/> Oppositional                | <input type="checkbox"/> Difficulty separating | <input type="checkbox"/> Withdrawal from others |
| <input type="checkbox"/> Overactivity                | <input type="checkbox"/> Physically aggressive | <input type="checkbox"/> Verbally aggressive    |
| <input type="checkbox"/> Rigid                       | <input type="checkbox"/> Withdrawn             | <input type="checkbox"/> Temper tantrums        |
| <input type="checkbox"/> Destructiveness             | <input type="checkbox"/> Tics                  | <input type="checkbox"/> Nail biting            |
| <input type="checkbox"/> Excessive blinking          | <input type="checkbox"/> Rocking               | <input type="checkbox"/> Thumb sucking          |
| <input type="checkbox"/> Hair pulling                | <input type="checkbox"/> Daydreaming           | <input type="checkbox"/> Bedwetting             |
| <input type="checkbox"/> Lying                       | <input type="checkbox"/> Stealing              | <input type="checkbox"/> Alcohol/drug use       |
| <input type="checkbox"/> Legal issues/involvement    | <input type="checkbox"/> Gang involvement      | <input type="checkbox"/> Sexual activity        |

81. Do you have any community organizations involved with your family (i.e. DCF, Probation):

- Yes
- No

If so, please explain:

---

## Educational History

82. Does your child currently attend school?

- Yes
- No

83. Where does your child currently attend school?

Teacher:

Grade:

---

84. Does your child attend any before/after school program(s)/activities?

- Yes
- No

If yes, please describe:

---

85. Does your child exhibit any academic difficulties?

- Yes
- No

If so, please explain.

---

86. Does your child attend school regularly?

- Yes
- No

If no, please explain.

---

87. Are there any attendance concerns

- currently or
- historically?

If so, please describe when and the reason.

---

88. Has your child had any interdisciplinaty incidents?

- Yes
- No

If so, please describe when and the reason.

---

89. Has your child ever been retained?

- Yes
- No

If so, what grade and school?

---

90. Has your child received any extra support in/outside of school?

- Yes
- No

If so, please explain:

---

91. Does your child receive any Tier II and/or Tier III Interventions for academic/behavioral support?

- Yes
- No

If so, please explain:

---

92. Has your child ever been tested for special education services before?

- Yes
- No

If so, when and what was the outcome?

---

93. Does your child have an Individualized Educational Plan (IEP) or 504 Plan for school?

- Yes
- No

If so, please briefly explain what it addresses.

---

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

---

---

---

---

95. Does your child have friends at school?

- Yes
- No

96. Any additional information pertinent to your child's school history?

- Yes
- No

Please explain:

---

## Concerns

Please check all areas that are a concern.



**97. Academics:**

- reading
- organization (school materials)
- writing
- math skills

**98. Self-Care:**

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

**99. Social/Emotional Development:**

- emotional regulation
- attention
- fears
- making friends
- coping skills
- problem solving

**100. Communication:**

- understanding directions
- understanding nonverbal language (gestures/facial expressions)
- expressing self clearly and concisely
- using appropriate voice
- understands vocabulary
- understands nonverbal language (gestures/facial expressions) comprehending conversations/stories
- using appropriate vocabulary/grammar
- using appropriate fluency
- understands conversation
- understands academic instruction
- using appropriate speech clarity

**101. Motor:**

- walking
- balance
- writing
- running
- posture
- drawing
- jumping
- endurance

**102. Sensory:**

- sitting still when expected
- sensitivities to sounds/clothes/textures and/or visual stimulation
- overly seeking movement
- able to handle transitions well

**103. How long have you had these concerns?**

---



---



---



---

104. Any significant factors that may have contributed to the concern?

Yes

No

If so, please explain:

---

105. What are your goals/expectations for therapy?

---

---

---

---