Kidtalk
Advanced Children's Therapy

GENERAL CASE HISTORY FORM

Kid Talk requests this information for the sole purpose of completing a thorough evaluation on your child. Completion of this form is required prior to your scheduled evaluation or your child's appointment may need to be rescheduled.

GENERAL INFORMATION:

Child's Name:	Date of Birth:	Age:
Person Providing the Information:	Today's Date:	Sex:
Child's Address:	Phone Number: Cell Phone Number:	Insurance Plan:
Physician:	Referring Clinic:	Referred By:

Father's Name:	Occupation:
Mother's Name:	Occupation:
Are parents (circle one): Married Separated Divorced Remarried	

I am requesting the following services: (please complete additional forms for the service(s) requested)

- □ Speech/Language Therapy
- □ Occupational Therapy
- □ Feeding Therapy
- □ Stuttering Therapy
- □ Literacy Therapy
- □ Orofacial Myology Therapy

BACKGROUND INFORMATION:

Presenting problem/reason for referral (please check all that apply):

□ Parent/Physician concerned about speech development and intelligibility
□ Parent/Physician concerned about language development
□ Parent/Physician concerned about social skills
□ Parent/Physician concerned about reading/literacy skills

□ Parent/Physician concerned about memory/executive functioning skills
□ Parent/Physician concerned about feeding skills
□ Parent/Physician concerned about fine motor skills/handwriting
□ Parent/Physician concerned about sensory processing
□ Parent/Physician concerned about gross motor skills
□ Parent/Physician concerned about self-care skills
□ Parent/Physician concerned about visual-perceptual skills
□ Physician referred for voice therapy due to _____

When did you first notice the problem? _____
What techniques have you tried at home? _____
Has your child withdrawn from situations?: □ yes □ no □ NA
Is our child is aware of his/her difficulties?: □ yes □ no □ NA
Please describe your primary concern(s):_____
Please describe your main goal(s) for therapy if recommended?_____

PREGNANCY/DELIVERY HISTORY:

Complications during pregnancy:_____
□ Full-Term □ Premature
Drugs or medications taken during pregnancy: _____
□ Vaginal delivery □ Cesarean □ Forceps/Suction were used
Birth Weight/Length: _____
Normal weight gain as an infant: □ yes □ no
Normal sleeping cycles as an infant: □ yes □ no
Normal temperament as an infant: □ yes □ no

Please check all that apply:
□ Jaundice
□ Required oxygen or respiratory assistance after birth
□ Difficulties with feeding/sucking/latching
□ Health problems/illnesses during the first 2 weeks of life_____
□ Thumb/digit sucking, nail biting, tongue sucking, and/or used pacifier, if yes, what age did it cease? _____

MEDICAL HISTORY:

Medical history is significant for the following (please check all that apply):

□ Congenital Defects
□ Recurrent Ear Infections/fluid in ears
□ PE Tubes
□ Hearing Loss
□ RSV
□ Diabetes
□ Heart Problems
□ Headaches
□ Tremors
□ Lung Bronchial Problems
□ Environmental and/or Food Allergies (please list):_____
□ Tonsil/Adenoid Problems
□ Meningitis
□ Seizures
□ Cleft Palate/Lip
□ Vision Problems (circle one): Near Sighted, Far Sighted, Other
□ Gastroesophageal Reflux
□ Avoids/dislikes tooth brushing
□ Breathes or snores through nose/mouth
□ Sleep issues
□ Nutrition concerns
□ Currently taking medication (please list meds and what they are for_____
□ Diarrhea
□ Constipation
□ Neurological problems
□ Picky eater
□ Failure to thrive
□ Feeding difficulties

Most recent hearing testing was completed on _____and revealed (please check one):
□ Normal hearing bilaterally (date)
□ Abnormal results (please describe): _____
□ Not completed

Other medical concerns/diagnoses:_____
Other medical evaluations/therapy completed(when and where):_____
Hospitalizations and/or surgeries:_____

DEVELOPMENTAL HISTORY:

□ Reached milestones at the following ages:

sat up at _____	drank from a cup at _____
crawled at _____	used a spoon _____
walked at _____	dressed independently at _____
produced first word at_____	potty trained at _____

Describe your child's strengths: _____
List some of your child's interests: _____

FAMILY HISTORY

Please check all that apply:
□ Speech-Language Delays
□ Learning Disabilities
□ Stuttering
□ ADHD/ADD
□ Hearing Loss
□ Autism/PDD
□ Mental Health
□ Adopted (at what age and from where): _____
□ Siblings (please list names and ages): _____
□ No family history

SLEEP HISTORY:

Please check all that apply:
□ Wakes frequently
□ Drools
□ Grinds teeth
□ Snores
□ Bed wetting
□ Sleeps with mouth open
□ Restless sleeper
□ Difficulty falling asleep

EMOTIONAL/SOCIAL HISTORY:

Please check all that apply:

□ easily managed at home
□ understands praise and reward
□ understands punishment
□ empathizes with others
□ recognizes danger
□ shows affection towards familiar adults
□ has friends
□ interacts with same aged children
□ plays well with others
□ usually happy/content
□ easygoing
□ shares with others
□ reacts appropriately in social situations
□ reads social cues

□ frequent temper tantrums
□ difficulty separating from caregiver
□ nervous habits or tics
□ frustrates easily
□ impulsive
□ resistant to change
□ restless
□ mostly quiet
□ talks frequently
□ over reacts
□ has unusual fears
□ shy, compliant
□ exhibits difficulty learning new tasks
□ stubborn
□ difficulty with transitions
□ fixates on objects/toys

□ rocks self frequently
□ avoids touch
□ craves touch, seeks it out
□ over active
□ tires easily
□ bites frequently
□ clumsy
□ overly cautious
□ fights frequently
□ poor attention span
□ other _____

***Is there anything else that would be helpful to the therapist to better understand your child? _____**
_____

EDUCATIONAL HISTORY:

Grade: _____ School Attending: _____
Child has experienced difficulty focusing/concentrating in school: □ yes □ no □ NA
Child has experienced difficulty sitting still in school: □ yes □ no □ NA
Child has experienced disruptive behaviors in school: □ yes □ no □ NA

Receives services in school: frequency_____ □ 1:1 □ group □ NA
Kid Talk can communicate with the school therapist: □ yes □ no □ NA

Parents perceive child's academic skills: □ above average □ average □ below average □ NA
Parents perceive child's intelligence relative to peers: □ above average □ average □ below average □ NA
Parents perceive child's social maturity: □ above average □ average □ below average □ NA