PARAMOUNT
Rehabilitation Services

CHILD CASE HISTORY FORM

Paramount Rehab Services requests this information for the sole purpose of completing your evaluation. Completion of this form is required prior to your scheduled evaluation. Failure to provide the required information will result in an incomplete examination or cancellation of the assessment.

Child's Name: ____________________________________ **DOB:** _________________

Parent/Guardian: ________________________________ **Date:** _________________

Please check the reason for the evaluation:

Explain your concerns about your child:

Fine motor ____
Gross Motor ____
Speech ____
Language ____
Sensory ____
Mobility ____
Feeding ____
Behavior ____

Requesting which therapy?

Occupational Therapy ____
Speech Therapy ____
Physical Therapy ____

Please list diagnosis, if any, who diagnosed, and when your child was diagnosed:

____
____

**** THERAPY PRECAUTIONS –** Please be specific

Does your child have any known allergies that you are aware of (i.e. food, latex)? Please list.	**YES**	**NO**	**LIST**
If your child has Down Syndrome, has he/she been diagnosed with Altantoaxial Instability? Are there any movement restrictions?	**YES**	**NO**	**LIST**
Are there any precautions not listed above that we should know about. Please describe (i.e. dietary restrictions)	**YES**	**NO**	**LIST**

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**** FAMILY HISTORY**

Father's Name: _____________________________ Age: ______ Occupation: ___________
Mother's Name: ____________________________ Age: _______ Occupation: __________
Is child adopted? _______ If so, what age and from where/what country? _____________
Are parents: Married Living Together Separated Divorced Remarried
Who lives in the house with this child, other than the parents? (If children are listed, please give names and ages)
Has there been any instances of the following in your immediate or extended family members? ADHD Learning Disabilities Autism/PPD Communication Disorders Hearing Loss Stuttering

**** PREGNANCY AND BIRTH HISTORY**

	YES	NO	COMMENTS
1. Were there any illness, injuries, bleeding, or any other complications during pregnancy? Describe.			
2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery?			
3. Were any drugs or medications taken during this pregnancy? If so, please specify.			
4. Was labor and delivery normal?			
5. Please list birth weight and length.	**X**	**X**	
6. Was this delivery vaginal, breech, or caesarian? Were forceps/suction used?	**X**	**X**	
7. Did you child experience jaundice?			
8. Was there a need for oxygen or respiratory assistance?			
9. Were there difficulties with feeding?			
10. Did you child bottle feed or breast feed?			
11. Did you child have difficulties sucking?			
12. Number of siblings.	**X**	**X**	
13. Which pregnancy was this child?	**X**	**X**	
14. Are there any issues with sleep patterns? If so, please explain			

** MEDICAL HISTORY PART ONE

15. Has you child had any of the following illnesses? Please list treatments/medications used. If you answer yes to any of the following, please notify receptionist for an additional form to fill out.	YES	NO	Comments
a. H1N1			
b. MRSA			
c. TB			
d. VRE			
e. Open Wound			
f. Lice			
g. Scabies			
h. Pink Eye			
i. Recent cough/cold			

**MEDICAL HISTORY PART TWO

16. Has you child had any of the following illnesses? Please list treatments/medications used.	YES	NO	Comments
a. Meningitis			
b. Chicken Pox			
c. Seizures			
d. Frequent Ear Infections Please note if patient has P.E. tubes and include last hearing test results, where and when completed.			
e. Excessive vomiting or reflux. Does/did your child have irritability/fussiness following feedings? Please describe. Please note any current or previous feeding or swallowing difficulties. Describe.			
f. Cleft Palate			
g. Does your child have vision problems?			
h. Does your child use any adaptive equipment? Describe.			
i. Is there a history of respiratory illnesses or asthma?			
j. Is there a history of abuse (physical or sexual)?			
k. Is your child on medications? Please list current and past.			
l. Please describe any pertinent medical conditions not mentioned above (i.e. accidents, injuries, etc.)	**X**	**X**	

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**** GROWTH AND DEVELOPMENT**

17. What age did your child:	**AGE/COMMENTS**
a. roll over from stomach to back?	
b. roll from back to stomach?	
c. sit independently?	
d. crawl?	
e. cruise around furniture?	
f. walk independently?	
g. babble?	
h. speak first word?	
i. speak 2 word sentences?	
j. drink from an open cup? What kind of cup does your child currently use?	
k. use a spoon?	
l. dress independently?	
m. toilet trained?	
n. toilet trained through the night?	

Check the following items that your child is able to do:
Jump up and down   Hop on one foot-Skip   Catch a Ball-Kick a ball   Climb descend stairs w/alternate ft
Hand Preference: Right   Left

18. Describe your child	**YES**	**NO**	**COMMENTS**
a. is mostly quiet			
b. is overly active			
c. tires easily			
d. talks constantly			
e. impulsive			
f. restless			
g. stubborn			
h. resistant to changes			
i. overreacts			
j. fights frequently			
k. is usually happy			
l. has frequent temper tantrums			
m. is clumsy			
n. has difficulty separating from caregiver			
o. has nervous habits or tics			
p. has poor attention span			
q. is easily frustrated			

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GROWTH AND DEVELOPMENT- CONTINUED

r. has unusual fears. Please describe	YES	NO	Comments
s. rocks self frequently			
t. exhibits difficulty learning new tasks			
u. avoids touch			
v. craves touch, seeks it out			
w. shy, compliant			

COMMUNICATION HISTORY

	COMMENTS		
19. How does your child communicate at home, at school…? (i.e. sign, PECs, verbal, augmentative/alternative communication device?			
20. Estimate how many words are in your child's vocabulary?	Expressive (speaking vocabulary) _____ under 25 ______ 25-75 ______ over 75 Receptive (words they understand) _____ under 25 ______ 25-75 _______ over 75		
21. Does your child	**YES**	**NO**	**COMMENTS**
a. point or gesture to communicate needs instead of verbal communication?			
b. understand and follow simple directions?			
c. identify body parts?			
d. recognize pictures of common objects?			
e. turn his/her head when name is called?			
f. communicate with intent?			
g. answer "wh" questions?			
22. Does you child have a hearing loss?			
23. Does your child use a pacifier/nuk/suck thumb?			
24. Is a language other than English spoken at home? If so, which one?			
25. Please describe any communication difficulties.	X	X	
26. When was the problem first noticed	X	X	

**** SOCIAL/EMOTIONAL DEVELOPMENT**

	YES	NO	COMMENTS
27. Is your child easily managed at home?			
28. Who manages him/her best?			
29. Does your child empathize with other feelings (happy, sad, angry…)?			
30. Does your child understand punishment and does he/she show remorse?			
31. Does your child understand praise and reward?			
32. Does your child recognize danger (climbing on ladders…)?			
33. Does your child show concern when separated from parents?			
34. Is your child affectionate toward familiar adults?			
35 Does your child have friends?			

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**** EDUCATIONAL BACKGROUND**

	Yes	No	
36. Does your child attend school? Where?			
37. What grade is he/she in now?	X	X	
38. Does your child receive special education or therapies in school (OT, PT, Speech, frequency, length of sessions, individual/group)?			
39. What is his/her current teacher's name?	X	X	
40. May we communicate with school staff? Please complete "Consent Form."			
41. Does your child receive therapy in school? If so, please describe. Please list names/phone numbers. (If applicable, please provide a copy of your child's current IEP. This will help us provide treatment without duplication of services)			

****MISCELLANEOUS INFORMATION**

41. Please list where your child has received therapy or treatment related to his/her present problems:	
42. Briefly describe a typical day with your child.	
43. Describe your child's strengths:	
44. What are your treatment priorities for your child?	