MEDICAL/CASE HISTORY FORM

Patient Name: ______________________________ Age: __________ Date of Birth: __________________

Child's primary language: ☐ English ☐ Spanish ☐Bilingual ☐ Other Language: ___________________________

Is there a language other than English spoken in the home? ☐ Yes ☐ No If yes, what language: ________________

☐ Yes ☐ No Does the child speak the language?
☐ Yes ☐ No Does the child understand the language?

Who speaks the language in the home? ____

Which language does the child prefer to speak at home? _______________________________________

Birth History

Length of Pregnancy (in weeks): ________________

Pregnancy Proceeded: ☐ Without Complications

☐ With Complications (Please explain): ____

____

____

Complications During or Following Birth:
☐ No Complications
☐ Complications (Please explain): ____

____

____

Medical History

Has your child had any of the following?

☐ Adenoidectomy	☐ Asthma/Respiratory Issues	☐ Ear Infections	☐ Ear Tubes
☐ Encephalitis	☐ Feeding Issues	☐ Head Injury	☐ Sleeping Difficulties
☐ Tube Feeding	☐ Thumb/Finger Sucking	☐ Tonsillectomy	☐ Tonsillitis

☐ Other: ____

Allergies: ____

Current Medications: ____

Current Vitamins, Herbs, Minerals: ____

Special Diet: ____

Diagnosed or Suspected Syndromes/Disorders:

☐ Autism/Asperger's/PDD-NOS	☐ ADD/ADHD
☐ Down Syndrome	☐ Intellectually Disabled
☐ Fragile X Syndrome	☐ Specific Learning Disability

☐ Other:____

If your child has been diagnosed with a Disorder or Syndrome please answer the following questions:

Agency/Professional who made the diagnosis: ____________________

Date Diagnosed: ____________________

Has your child seen any specialists (i.e. audiologist, ENT, Neurologist, Psychiatrist, etc.)? ☐ Yes ☐ No

If yes, please list type of specialist and name ____________________

____

____

Please list any surgeries or procedures? ____________________

____

Hearing and Vision

Hearing

Hearing Screening/Test:

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
  - Date: __________
- ☐ Abnormal Test Results
  - Date: ________________

Vision

Vision Screening/Test:

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
  - Date: ________________
- ☐ Abnormal Test Results
  - Date: ________________

Hearing Checklist:

☐ YES ☐ NO Responds negatively to unexpected or loud noises?

☐ YES ☐ NO Doesn’t respond when name is called?

☐ YES ☐ NO Can’t work with background noise?

☐ YES ☐ NO Talks Louder than anyone else in the room?

Vision Checklist:

☐ YES ☐ NO Looks at people and/or toys?

☐ YES ☐ NO Has a difficult time finding objects in cluttered areas?

☐ YES ☐ NO Squints or closes one eye when reading or with written work?

☐ YES ☐ NO Prefers to be in a dimly lit room?

☐ YES ☐ NO Difficulty copying from board?

Social & School Information

Child lives with: ☐ Biological Mother ☐ Biological Father ☐ Both Biological Parents ☐ Foster Parents ☐ Adoptive Parents ☐ Grandparents ☐ Stepmother/Stepfather ☐Other: ____________

# of Siblings: _____________Older _____________Younger _____________ Twin/Triplet/Other

How does your child interact with other children:
☐ Does not prefer to play with other children ☐ Plays well with other children
☐ Prefers to play with children his/her own age ☐ Prefers to play with children younger/older
☐ Plays aggressively with other children

Educational Information
If your child is in school, please answer the following questions:
Name of School and District: ____ Grade in School: ___________________

Has your child repeated a grade? ☐ Yes ☐ No If yes, what grade: _______________

☐ Yes ☐ No Has your child ever had a special education evaluation at school (includes speech therapy evaluation)?

☐ Yes ☐ No Does your child receive special education services at school (includes speech therapy)?

What type of classroom is your child in at school?

☐ General education ☐ PPCD ☐Resource/Content Mastery ☐ Life Skills ☐ Other: ___________________

What services does your child receive at school?

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Dyslexia ☐ Tutoring

☐ Other: __________________

Previous Services

Has your child received therapy services from another clinic/private agency in the past?
☐ YES ☐ NO Speech Therapy
☐ YES ☐ NO Occupational Therapy
☐ YES ☐ NO Behavioral (ABA) Therapy
☐ YES ☐ NO Other: ________________

If yes, please provide the following details:

Therapy Agency Name: ____

Dates Therapy was Received: ____

Reason Discontinued: ____

____

Printed Name of Parent/Guardian Completing Form

____ ________________________

Parent/Guardian Signature Date