EDUCARE THERAPY
Pediatric Learning Center

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

Pregnancy Proceeded: ☐ Without Complications

☐ With Complications

☐ Eclampsia ☐ Pre-Eclampsia
☐ Gestational Diabetes ☐ Premature Labor
☐ High Blood Pressure ☐ Other: _____

Length of Pregnancy (in weeks): _____ Prenantal care was: ☐ Received ☐ Not Received

Mother's age at time of birth: _____ Birth Hospital: _____

Delivery Proceeded: ☐ Without Complications

☐ With Complications

☐ Breech Presentation ☐ Umbilical cord around neck
☐ Low Amniotic Fluid ☐ Placenta Previa
☐ Meconium Aspiration ☐ Use of Forceps
☐ Other: _____

Delivery was: ☐ Vaginal ☐ C-Section ☐ Emergency C-Section Days in Hospital: _____

Birth Weight: _____ Birth Height: _____ Apgar: 1 min _____ 5 min _____ 10 min _____

Complications Following Birth: ☐ No Complications

☐ Complications

☐ Anemia of Prematurity ☐ Brachial Plexus Injury
☐ Bronchopulmonary Dysplasia ☐ Cleft Lip/Cleft Palate
☐ Club Foot ☐ Congenital dislocation of hip
☐ Congenital Heart Disease ☐ Failure to Thrive
☐ IVH Bleed Grade 2-3 ☐ Respiratory Distress Syndrome
☐ Retinopathy of Prematurity ☐ Ventilator Dependency
☐ Other: _____

Other Pregnancy/Delivery Information: _____

_____

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: _____

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?

Hearing Concerns:_____
_____

Vision

Vision Screening/Test:

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

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?

Vision Concerns:_____
_____

*Please note that we require a current vision and hearing screening to be on file while your child is receiving therapy.

Sensory/Motor

Please tell us about your child's developmental milestones by placing a check in the appropriate column.

Milestone	Met at Appropriate Time	Delayed (List age met)	Has Not Met	Additional Comments
Rolled over				
Held head up alone				
Sat without support				
Grabbed Toys				
Crawled alone				
Pulled self to standing				
Walked unaided				
Toilet trained				
Grasped crayon/pencil				

How does your child get around the house? _____

What hand does your child prefer? ☐ Left ☐ Right ☐ No Preference ☐ Unsure

Fine Motor Checklist:

☐ Yes ☐ No Completes puzzles or "in/out" objects (e.g. shape sorter)?
☐ Yes ☐ No Weak grasp resulting in difficulty with buttons, zippers, and snaps?
☐ Yes ☐ No Difficulty grasping a pencil and cutting with scissors?

Tactile Checklist:

☐ Yes ☐ No Shows a negative response when touched or when touching other objects?
☐ Yes ☐ No Enjoys movement such as swinging or rocking?
☐ Yes ☐ No Has specific clothing preferences/clothing dislikes?
☐ Yes ☐ No Avoids touching "messy" items (e.g. food, finger paint, shaving cream)?
☐ Yes ☐ No Overreacts to nail cutting, hair washing, bathing, or other forms hygiene?

Movement and Balance Checklist:

☐ Yes ☐ No Falls down frequently, bumps into things, trouble with balance, poor coordination?
☐ Yes ☐ No Fearful when feet leave the ground?
☐ Yes ☐ No Avoids climbing on playground equipment?
☐ Yes ☐ No Seeks out movement and described as "on the go"?

Sensory/Motor Concerns: _____

_____

_____

Feeding

Please tell us about your child's developmental milestones by placing a check in the appropriate column.

Milestone	Met at Appropriate Time	Delayed (List age met)	Has Not Met	Additional Comments
Began using a bottle				
Began using a pacifier (if applicable)				
Began eating baby food				
Began eating junior food				
Began eating table food				
Began using a straw				
Began using a "sippy" cup				
Began drinking from a cup without a lid				
Began using utensils for eating				

Feeding Checklist:

☐ Yes ☐ No Avoids certain tastes/textures that are typically part of a child's diet?
☐ Yes ☐ No Gags when presented with certain foods/smells?
☐ Yes ☐ No Constantly chews on objects (e.g. pencil, clothing, fingers)?
☐ Yes ☐ No Seeks out certain tastes/smells?
☐ Yes ☐ No Chokes on foods and/or liquids?

Food Likes: _____

Food Dislikes: _____

Has your child ever had a Modified Barium Swallow Study (MBSS) conducted? ☐ Yes ☐ No

If yes, please provide the following details:

Agency/Professional who conducted the swallow study: _____

Date of the swallow study: _____

Results: _____

*Please note: If a patient is receiving therapy for Dysphagia due to aspiration then we require that a current swallow study be on file at all times.

Feeding Concerns: _____

_____

Speech/Language

Please tell us about your child's developmental milestones by placing a check in the appropriate column.

Milestone	Met at Appropriate Time	Delayed (List age met)	Has Not Met	Additional Comments
Babbled				
Spoke First Words				
Named familiar objects				
Combined 2 words				
Used phrases/sentences				
Began participating in conversation				
Began to read				

What is your child's primary type of communication? ☐ Non-Verbal ☐ Verbal

☐ Body Language ☐ Sign Language ☐ Pointing/Gestures ☐ Eye Gaze ☐ Picture Exchange System

☐ Vocalizations ☐ Single Words ☐ Phrases/Sentences ☐ Conversation ☐ Communication Device

Speech/Language Checklist:

☐ Yes ☐ No Repeats sounds, words, or phrases, over and over (e.g. stuttering)?
☐ Yes ☐ No Understands what you are saying?
☐ Yes ☐ No Points to common objects upon request (e.g. shoe, ball, cup)?
☐ Yes ☐ No Follows simple directions (e.g. "Shut the door")?
☐ Yes ☐ No Responds correctly to yes/no questions?
☐ Yes ☐ No Responds correctly to who, what, when, where, why questions?
☐ Yes ☐ No Makes sound-letter correlations (B says "b")?
☐ Yes ☐ No Answers questions about a story read aloud?
☐ Yes ☐ No Uses appropriate grammar (e.g. verb tense, plurals, pronouns) when speaking or writing?

Speech/Language Concerns: _____

_____

_____

Social & School Information

Social/Behavior:

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 would you describe your child:

☐ Active	☐ Cautious	☐ Distractible	☐ Insecure	☐ Playful
☐ Affectionate	☐ Curious	☐ Fearful	☐ Motivated	☐ Shy
☐ Aggressive	☐ Demanding	☐ Fearless	☐ Passive	☐ Stubborn
☐ Calm	☐ Difficult to Comfort	☐ Fussy	☐ Persistent	☐ Withdrawn

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 Prefers to play with: ☐ Boys ☐ Girls ☐ No Preference

What are your child's favorite toys, characters, and/or play activities: _____

_____

☐ Yes ☐ No Difficulty finishing a task before moving onto another task?
☐ Yes ☐ No Difficulty paying attention?
☐ Yes ☐ No Difficulty transitioning from task to task?
☐ Yes ☐ No Difficulty with changes in schedule or routine?
☐ Yes ☐ No Difficulty with behavior (following rules, controlling temper or emotions,etc.)?

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: _____

Additional Information

Has your child received therapy services from another 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: _____

Has your child ever had any other types of evaluations or therapy not listed above (i.e. Evaluation at the Child Study Center, Psychoeducational Evaluation, Autism Evaluation ,etc.)? ☐ YES ☐ NO

If yes, please provide the following details:

Agency/Name of professional who conducted the evaluation: _____

Date of Evaluation: _____

Evaluation Findings: _____

_____ _____

Parent/Guardian Signature Date