BRAZOS VALLEY REHABILITATION CENTER
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PEDIATRIC CASE HISTORY FORM

Patient Name: _____ Age: _____ Date of Birth: _____

Referring Physician: _____

Diagnosis: _____ Date of Onset: _____

Areas of concern: **check all that apply*

- ☐ Speech Articulation (pronouncing sounds/words)
- ☐ Receptive Language (following directions, understanding language)
- ☐ Expressive Language (forming sentences, expressing self)
- ☐ Social Skills
- ☐ Stuttering
- ☐ Voice
- ☐ Feeding/Swallowing
- ☐ Play Skills
- ☐ Reading
- ☐ Attention
- ☐ Behavior
- ☐ Unable to sit still
- ☐ Fine Motor (handle small items with fingers)
- ☐ Hand-writing
- ☐ Sensory
- ☐ Gross Motor (sitting, walking, throwing, jumping)
- ☐ Difficulty turning head
- ☐ Frequent falls/clumsy

Describe your concerns and goals for therapy: _____

_____

Pregnancy/Birth History:

Pregnancy: ☐ Normal ☐ Abnormal/Complications (explain) _____

_____

Delivery: ☐ Vaginal ☐ Cesarean Birth weight: ____lbs. ____ oz. Premature: ☐ No ☐ Yes # of weeks born at: _____

Postnatal History: ☐ Jaundice ☐ Required Oxygen ☐ Other: _____

Physical Abnormalities: _____ Feeding/Swallowing Problems: _____

Birth Injuries: _____

Medical History:

Is your child taking medicine? ☐ Yes ☐ No

List medications: _____

Is your child allergic to any of the following? ☐ latex ☐ food ☐ medication ☐ other If yes, *list*_____ ☐no

*****Has your child had any of the following?

☐ Surgery/hospitalization	☐ Heart problems	☐ Vision problems	☐ Seasonal allergies	☐ Diabetes	☐ Movement limitations
☐ Serious accident/injury	☐ Digestive problems	☐ Hearing problems	☐ Ear infections	☐ G-Tube	☐ Frequent falls
☐ Chronic illness	☐ Breathing problems	☐ Swallowing problems	☐ Tubes in Ears	☐ Seizures	☐ Joint problems
☐ Genetic disorder/Syndrome	☐ Neurological problems	☐ Sleeping difficulties	☐ Acid Reflux/GERD	☐ Body pain	☐ Other

***Please explain any checked items here:* _____

_____

Vision/Hearing:

Has the child had a hearing test? ☐ Yes ☐ No Results? _____

When? _____ Where? ☐ school ☐ Physician ☐ Audiologist ☐ ENT ☐ hospital

Recommendations? ☐ audiological evaluation ☐ hearing aid ☐ cochlear implant ☐ other _____ ☐ none

Has the child had a vision test? ☐ Yes ☐ No Results? _____

Does your child wear glasses? ☐ Yes ☐ No

Developmental Milestones:

Developmental Skill	Age Achieved	Developmental Skill	Age Achieved
Lift head while on tummy		Stand alone	
Roll		Walk	
Sit alone		Babble	
Hold toys while sitting		First word	
Crawl on tummy/crawl on all fours/scoot on bottom		Put 2 words together	
Walk sideways using furniture		Taken off bottle/breast	

Potty trained			

Speech & Language:

Language(s) besides English spoken in the home? ☐ Yes ☐ No If yes, what language(s)?_____
Language child understands best?_____ Language child speaks most often?_____
How does your child communicate the majority of the time? ☐ pull you to object ☐ gesture/point ☐ make sounds ☐ words ☐ phrases
☐ sentences ☐ sign language ☐ communication book ☐ communication device ☐ other_____
What does your child understand? *Check all that apply.* ☐ simple directions ☐ 2-step directions ☐ wh- questions ☐ yes/no questions ☐ conversation
How much can the parents understand of their speech? ☐ all ☐ most ☐some ☐ none
How much can others understand of their speech? ☐ all ☐ most ☐some ☐ none
List sounds that your child has trouble pronouncing:_____

Feeding History:

Does the child have trouble swallowing? ☐Yes ☐ No
Has the child had a swallow study? ☐Yes ☐ No
If yes, list results/recommendations: _____
Is the child a "picky" eater? ☐ Yes ☐ No
Is the child a messy eater? ☐ Yes ☐ No
Does child have difficulty chewing? ☐ Yes ☐ No
Avoids certain food textures/temperatures? ☐ Yes ☐ No
Sensitive in/around mouth/face/head ☐ Yes ☐ No
Does the child drool? ☐ Yes ☐ No
Was weaning a problem? ☐ Yes ☐ No

Family History:

Who is your child's legal guardian? ☐ parents ☐ mother ☐ father ☐other, *list name and relationship*_____
Marital status of parents: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed Is your child adopted? ☐ Yes ☐ No
List everyone in the child's primary household: _____
#of adults in the home: _____ # of children in the home: _____ Ages of children: _____
What does your child spend most of his time at home doing? _____
_____
Have any relatives had developmental delays, physical problems or learning disabilities/disorders? If yes, *please list*. _____
_____
Are there stairs in the home? ☐ Yes ☐ No If yes, how many? _____ Is there a handrail? ☐ Yes ☐ No

School History:

Does your child attend a day care or school? ☐ Yes ☐ No If yes, where? _____
What is their current grade level? _____ Does your child have an aide? ☐ Yes ☐ No
Has your child repeated a grade? ☐ Yes ☐ No If yes, what grade? _____
Are they in a special program or class? ☐ Yes ☐ No If yes, *list* _____
Does your child receive therapy at school? ☐ Yes ☐ No If yes what? ☐PT ☐OT ☐Speech ☐Vision
What's your child's biggest difficulty at school? ☐particular subject(s), *list*_____
☐PE ☐getting along with peers ☐conduct/behavior ☐other, _____
On average, what are your child's grades? ☐A's (90-100) ☐B's (80-89) ☐C's (70-79) ☐F's (below 70)

Other:

Has your child seen any of the following professionals?

☐ Geneticist ☐ Neurologist ☐ Developmental Pediatrician ☐ Physical Medicine Rehabilitation Physician
☐ ENT ☐ Orthotist ☐ Behavioral Therapist ☐Speech-Language Pathologist
☐ Other ☐ Psychologist ☐ Physical therapist ☐ Occupational therapist

If you checked yes to any of the following, please list the name of the professional, when they were seen, and if applicable the resulting diagnosis:
_____
_____

Below is a list of words which describe a child's personality or behavior. Please check those which you feel tend to describe your child:

☐ Shy ☐ Hard to discipline ☐ Very Active ☐ Toe walker
☐ Happy ☐ Has temper tantrums, ☐ Independent ☐ Frequent faller
☐ Moody how often? _____ ☐ Dependent ☐ Slow moving
☐ Friendly ☐ Fights with peers/siblings ☐ Leader
☐ Clumsy/awkward ☐ Even tempered ☐ Follower
☐ Nervous/anxious ☐ Has trouble sleeping ☐ Prefers to be alone
☐ Perfectionist ☐ Sucks thumb/pacifier ☐ Quiet
☐ Easily frustrated ☐ Overly sensitive to touch/sound/smells ☐ Negative behaviors _____

_____ _____

Patient/Guardian Signature Date

Is there any other information we need to know?

_____

_____

_____

_____

_____

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_____.