Mary Lanning HEALTHCARE

Pediatric Rehabilitation

Pediatric Case History

Patient's Name:_____ Date of birth:_____ Sex: ❑ M ❑ F

Parent / Guardian's name:_____ Today's date:_____

May we contact you via email? ❑ Yes ❑ No Email address:_____

Reason for evaluation:_____

Patient's primary or referring physician:_____

Previous therapy: ❑ Speech ❑ Occupational therapy ❑ Physical therapy

If so, when:_____ where:_____

Reason for therapy:_____

What was the outcome:_____

Current height:_____ Current weight:_____

Allergies:_____

If so, describe your child's symptoms:_____

_____

What would you like us to do in the event of a reaction?_____

_____

Medications:_____

_____

My child lives with: ❑ Birth parents ❑ Foster parents ❑ One parent ❑ Adoptive parents ❑ Parent & step-parent

❑ Other _____

My child has: ❑ brothers_____

❑ sisters_____

Language(s) spoken to my child is/are: ❑ English ❑ Spanish ❑ Other:_____

My child spends most of his/her day at: ❑ home ❑ school ❑ daycare / babysitter

❑ Other_____

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General Development:

Does your child have any diagnosed medical conditions? ❑ Yes ❑ No

Describe any medical conditions, illnesses, diseases, or surgeries your child has had:_____

_____

Has your child ever had: ❑ Ear infections ❑ Tubes in ears ❑ Tonsillitis ❑ Tonsils removed

Any known abnormalities of the tongue, mouth, nose, throat, ears, head, or neck_____

_____

Does your child have any vision problems? ❑ Yes ❑ No ❑ I don't know

Does your child have any hearing problems? ❑ Yes ❑ No ❑ I don't know

Does your child have seizures? ❑ Yes ❑ No

If so, what do they typically look like?_____

What would you like us to do in the event that your child has a seizure during therapy?_____

_____

Has your child ever been to the dentist? ❑ Yes ❑ No

If Yes, when was the last visit:_____

Name of the dentist:_____

Has your child ever been to a Psychologist / Psychiatrist? ❑ Yes ❑ No

If Yes, when was the last visit:_____

Name of the Psychologist / Psychiatrist:_____

Does your child need an assistive device to be mobile? ❑ Yes ❑ No

If Yes, please indicate device: ❑ Wheelchair ❑ Walker ❑ Crutches ❑ Other:_____

Does your child need assistance for toileting? ❑ Yes ❑ No ❑ Sometimes

Does your child wet the bed? ❑ Yes ❑ No ❑ Sometimes ❑ Frequently

Does your child have accidents during the day? ❑ Yes ❑ No ❑ Sometimes ❑ Frequently

Birth History (if child is under the age of 5):

Delivery: ❑ Caesarean section ❑ Vaginal

Any complications during pregnancy or delivery? ❑ Yes ❑ No

If Yes, please explain:_____

Check those that apply: ❑ Forceps ❑ Suctions ❑ Oxygen ❑ Mechanical ventilation

How many weeks was the pregnancy?_____

Child's birth weight:_____

Birth History Cont'd:

Where was the child born?_____

Was the child transferred to another hospital? ❑ Yes ❑ No

If Yes, please explain:_____

How long did your child remain in the hospital after birth?_____

List the age your child first: supported head_____ rolled over_____ reached for objects_____

sat up_____ crawled_____ first word_____ walked_____

Feeding/swallowing:

Does your child have difficulty swallowing? ❑ Yes ❑ No

Does your child have reflux? ❑ Yes ❑ No ❑ I don't know

Does your child receive any or all nutrition through a feeding tube? ❑ Yes ❑ No

If yes, please explain:_____

Amount:_____ Rate:_____ NG:_____ PEG:_____ PEJ:_____

Bolus:_____ Continuous:_____

Has your child ever choked or gagged during a feeding/meal?_____

Was your child breast fed? ❑ Yes ❑ No

Does your child use utensils correctly? ❑ Yes ❑ No

What does your child drink out of? ❑ Bottle ❑ Breast ❑ Sippy cup ❑ Open cup ❑ Straw/cup

What does your child typically eat?_____

❑ Stage 1 baby food (smooth) ❑ Stage 2 baby food (semi-chunky) ❑ Stage 3 baby food (chunky)

❑ Regular liquids ❑ Thickened liquids ❑ Baby cereal ❑ Mashed table foods / puree ❑ Regular table foods

Favorite foods:_____

Foods child refuses or avoids:_____

Where does your child eat? Describe:_____

_____

Does your child eat more / less when he / she is at home versus daycare / school or vise-versa?_____

_____

Other:_____

_____

_____

Pediatric Case History

School / Work:

What school/daycare/babysitter does your child attend: _____

Current grade level: _____ Teacher's name: _____

Does your child currently have an IFSP, IEP, or IPP? _____

Does your child have a services coordinator? ❑ Yes ❑ No ❑ I don't know

Speech / Language:

My child communicates: ❑ Verbally ❑ With gestures or sign language ❑ With assistive technology ❑ Through behaviors

Do you think your child understands when you talk to him/her? ❑ Yes ❑ No ❑ Sometimes

Do you understand your child when he/she talks to you? ❑ Yes ❑ No ❑ Sometimes

Do other children understand your child when he/she talks to them? ❑ Yes ❑ No ❑ Sometimes

Does your child's voice sound like other children in terms of pitch, loudness, and clarity? ❑ Yes ❑ No ❑ Sometimes

Does your child play well with other children his/her age? ❑ Yes ❑ No ❑ Sometimes

Social / Emotional:

Do you have concerns for your own safety due to your child's negative behaviors? ❑ Yes ❑ No ❑ Sometimes

If Yes, please explain: _____

_____

Do you have concerns for your child's safety at home due to his/her own negative behaviors? ❑ Yes ❑ No ❑ Sometimes

If Yes, please explain: _____

_____

Please describe any behaviors your child exhibits at home: _____

_____

When are behaviors at home more likely? _____

_____

Does your child experience negative behaviors at school? ❑ Yes ❑ No ❑ Sometimes

If Yes, please explain: _____

_____

What appears to trigger your child's behaviors? _____

_____

What ways do you discipline? ❑ Spank ❑ Ignoring ❑ Time Out ❑ Other: _____

What strategies do you use to calm or redirect your child? _____

Are you interested in ideas for calming or redirecting your child? ❑ Yes ❑ No

Is your child currently under the care of a mental health professional ❑ Yes ❑ No

If Yes, please name the physician and date of last visit: _____

Self Cares:

What areas/skills does your child need assistance with at home? (***please check all that apply***):

❑ Put on shirt ❑ Pull up pants ❑ Brush Hair ❑ Brush Teeth ❑ Put on socks and shoes

❑ Button pants ❑ Tie Shoes ❑ Zip up coat ❑ Showering / Bathing

Sleep:

How many hours of sleep a night does your child typically get?_____

What is your child's typical bedtime during the summer?_____

What is your child's typical bedtime during the school year?_____

Does your child take naps? ❑ Yes ❑ No ❑ Sometimes

Is your child often sluggish or sleepy throughout the day? ❑ Yes ❑ No ❑ Sometimes

Play:

Does your child play well with children their same age? ❑ Yes ❑ No ❑ Sometimes

Does your child prefer to play alone or with others? ❑ Alone ❑ With others

What are your child's favorite toys to play with?_____

_____

Does your child like toys that: ❑ Light up ❑ Make noises ❑ Have various textures

Does your child play with age appropriate toys? ❑ Yes ❑ No ❑ Sometimes

Does your child use his or her imagination when playing? ❑ Yes ❑ No ❑ Sometimes

Examples: Have a tea party with stuffed animals, pretend to cook a meal with toy food

Gross Motor Development (children under 2):

Please check all the skills your child has mastered:

❑ Rolling tummy to back ❑ Rolling back to tummy ❑ Independent sitting ❑ Crawling

❑ Crawling up/down stairs ❑ Pull to stand at furniture ❑ Stand without support ❑ Cruise along furniture

❑ Walking ❑ Walking fast ❑ Running ❑ Jumping in place ❑ Walking up/down stairs

Goals for Therapy:

Please check all the areas / skills you would like addressed in therapy for your child:

❑ Speak more clearly ❑ Speak more words ❑ Fine motor skills ❑ Handwriting

❑ Sensory issues ❑ Improve attention ❑ Improve mobility ❑ Have a way to communicate

❑ Decrease behaviors ❑ Job skills ❑ Shoe typing ❑ Showering/Bathing

❑ Increase strength ❑ Balance ❑ Talk louder/quieter ❑ Eat a regular diet

❑ Dressing ❑ Read better ❑ Be more social ❑ Eat different foods

❑ Potty training ❑ Money Management ❑ Tooth brushing ❑ Play activities

❑ Increased participation in community activities ❑ Increased independence with chores/responsibilities at home

❑ Other:_____

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Parents: For the safety of your child, please provide us with the names, address, and phone numbers of any person allowed to pick up your child from therapy; ***we will not allow your child to leave our clinic if the person is not on that list or if we have not been notified prior that someone other than you will be picking up your child.***

Name:	Relationship to child:	Address:	Phone number: