



OUTPATIENT PEDIATRIC CASE HISTORY

Thank you for helping us get to know your child by completing this form. We realize that some of the questions are neither applicable nor appropriate for your child and you may leave those items blank.

General History

Name of Child: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Gender: Male Female

Address: _____

Home Phone: _____ Work phone: (father): _____ (mother): _____

Cell phone: (father): _____ (mother): _____

Father's Name: _____ Mother's Name: _____

Parent's Marital Status: Married Separated Divorced Single Widowed

Siblings' Name: _____ Age: _____

_____ Age: _____

_____ Age: _____

Child's Pediatrician/Clinic/Family Physician: _____

Concerns

Describe the nature of your concerns for your child: _____

When did you first become concerned about your child: _____

Has your child ever received any of the following evaluations by a doctor, at a clinic, or at a school: Yes No If yes:

	When	Where	Outcome
Physical Therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech/Language	_____	_____	_____
Hearing	_____	_____	_____
Vision	_____	_____	_____
Psychological	_____	_____	_____
Genetic	_____	_____	_____
What other findings or treatments were given:	_____		

What information do you hope to obtain from this evaluation: _____

Developmental History

Is this your: biological child adopted child foster child other: _____

Was this a normal pregnancy: Yes No Length of pregnancy: _____ Birth Weight: _____

Any complications: during pregnancy during birth after birth none

Did your child feed well after birth: Yes No If no, explain: _____

At what age did your child:

Hold head up _____
Roll over _____
Sit alone _____
Crawl (all fours) _____
Stand _____

Walk alone _____
Spoon feed self _____
Run _____
Dress self _____
Hand Preference Left Right

School History

Does your child attend: daycare pre-school elementary middle high school grade level _____

Name of school: _____

Repeated grades: _____

Exceptional education programs: _____

Teacher's name: _____

Have any learning problems been identified: _____

Academic areas of concern: _____

Will your child be starting daycare or preschool any time soon: _____

Behavior/Social/Motor History

Please mark if your child:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> avoids speaking | <input type="checkbox"/> withdraws from others | <input type="checkbox"/> walks on tip toes | <input type="checkbox"/> is sensitive to noises |
| <input type="checkbox"/> is aggressive | <input type="checkbox"/> does not play well | <input type="checkbox"/> falls frequently | <input type="checkbox"/> does not follow directions consistently |
| <input type="checkbox"/> is frustrated/angry easily | <input type="checkbox"/> cries easily | <input type="checkbox"/> hits her/him self | <input type="checkbox"/> dislikes certain textures of foods or clothes |
| <input type="checkbox"/> does not like to be touched | <input type="checkbox"/> is destructive | <input type="checkbox"/> is hyperactive | <input type="checkbox"/> coughs/choke on food |
| <input type="checkbox"/> is distractible | <input type="checkbox"/> eats poorly | <input type="checkbox"/> seems awkward/clumsy/uncoordinated | |
| <input type="checkbox"/> does not chew foods | <input type="checkbox"/> forgets easily | | |
| <input type="checkbox"/> spits up frequently | | | |

Home Environment

Are there any family concerns that would help us understand your child better? _____

What types of activities/toys does your child enjoy? _____

Where and with whom does your child spend most of his/her time? _____

List your child's strengths: _____

List your child's weaknesses: _____

Please complete the following section if your child is exposed to more than one language:

What language is primarily spoken at home: English Spanish Other: _____

What language do the parents speak to each other: English Spanish Other: _____

What language do the parents speak to this child: English Spanish Other: _____

What language does the child seem to prefer: English Spanish Other: _____

Speech and Hearing

At what age did your child:	Begin babbling _____	Speech/language seem to stop/regress _____
	Gesture _____	Respond to name _____
	Speak in sentences _____	Follow simple directions _____
	Say first word _____	Put 2-3 words together _____

How does your child communicate his/her needs:	<input type="checkbox"/> eye gaze	<input type="checkbox"/> pointing	<input type="checkbox"/> vocalization
	<input type="checkbox"/> words	<input type="checkbox"/> sign	<input type="checkbox"/> sentences
	<input type="checkbox"/> crying	<input type="checkbox"/> speech	<input type="checkbox"/> head nodding

Falls Risk Assessment

Is your child an independent walker? Yes No

If no, does your child use any of the following:

- wheelchair hand held assist
- cane or walker furniture / wall
- child does not walk

Does your child have any balance problems? Yes No

If yes, please describe: _____

Is falling a problem for your child? Yes No

If yes, is this a new problem? Explain: _____

Health Insurance Portability Accountability Act

We may be calling to remind you of:

- ❖ Appointments/cancellations/rescheduling
- ❖ Verify your personal health information
- ❖ Any supplies/medical equipment ordered is ready for pick up

If you are not available, we will be leaving a detailed message at (please indicate):

- Work – list phone number: _____
- Home – list phone number: _____
- Other - list phone number: _____
- E-mail address: _____

NO - please do not leave any messages.

Thank you for taking the time to complete this form! We hope to make this a positive experience for you and your child.