The Enrichment Garden, Inc
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Child Case History Form

General Information:

Child's Name: _____

Person Completing Form: _____ Date Completed: _____

Birth Date: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Family Information:

Does child live with both parents? _____ Yes _____ No

Mother's Name:		Age:	
Mothers Occupation:			
Father's Name:		Age:	
Fathers Occupation:			

Brothers and Sisters (include names and ages):

Primary Care Physician:

Name: _____

Address: _____ Phone: _____

Emergency Contact Information:

Name: _____ Relation: _____

Phone Number(s):_____

In the event of an emergency, what is your preferred hospital? _____

Prenatal and Birth History:

What was the mother's general health during pregnancy? Please list any accidents, illnesses, medications, etc.

Length of Pregnancy:		Length of Labor:	
General Condition:		Birth Weight:	
APGAR Scores:		Type of Delivery:	
Please list any unusual conditions:			

Current Medical History:

Has your child received any of the following?

	Yes	No	If yes, where?
Physical Therapy			
Occupational Therapy			
Speech Therapy			

Does your child have a medical diagnosis: _____ Yes _____ No

If yes, please fill out information below:

Date Diagnosed:		Who Diagnosed your child:	
What is the diagnosis:			

Has your child had the following?

	Yes	No	If yes, what were the results?
Hearing Test			
Vision Test			

Has your child had the following illnesses/condition?

	Yes	No	Age(s)	Type/Results
Allergies:				
Colds:				
Asthma:				
Croup:				
Dizziness:				
High Fever				
Encephalitis				
Measles:				
Pneumonia:				
Tinnitus:				
Convulsions:				
German Measles:				
Influenza:				
Meningitis:				
Seizures:				
Tonsillitis:				
Chicken Pox				
Croup:				
Ear Infections:				
Draining Ear:				
Tubes in ears:				
Headaches:				
Mastoiditis:				
Mumps:				
Sinusitis:				
Broken Bones:				
Casts/Braces:				
Other:				

List any medications your child is currently one with frequency and dosages:

Describe any major accidents or hospitalizations:

Describe any surgeries your child has had:

Describe any other specialists your child has seen (psychologists, psychiatrists, social workers, etc):

Are there any medical precautions the therapist should be aware of before working with your child? _____YES _____ NO

Developmental History

Provide the approximate ages your child began to do the following activities:

Sit:		Crawl:	
Walk:		Feed Self:	
Dress Self:		Use Toilet:	
Use Single Words:		Combine Words:	
Name Simple Objects:		Use Simple Questions:	
Engage in Conversations:			

Does your child have difficulty walking, running, or participating in other activities which requires small or large muscle coordination?

Does your child have any feeding concerns? (e.g. problems with sucking, swallowing, drooling, chewing, etc.)

Describe your child's response to sensory stimuli. (e.g. responds to all sounds, responds to loud sounds only, seeks things to touch, avoids certain textures, noises, etc.)

Do you perceive any speech-language communication concerns? Are there any other speech language concerns in your family?

How does your child usually communicate? (Circle one)

Gestures	Single Words	Short Phrases	Sentences	Non-verbal

Does your child have regular sleep patterns? _____ Yes _____ No
If no, please describe.

Does your child wake frequently during the night? _____ Yes _____ No
If yes, please describe.

Does your child have difficulty falling asleep? _____ Yes _____ No

Does your child tend to be an early riser, up and on the go? _____ Yes _____ No

Developmental/Sensory History:

Auditory and Language Processing					
	Often	Some-times	Rarely/ Never	N/A	Comments
Like to sing and dance?					
Have difficulty maintaining or copying rhythms?					
At times seem not to understand what is said?					
Seem overly sensitive to sounds?					
Become distracted by lots of noise?					
Become distracted by background noises?					
Seem to have trouble remembering what was said?					
Have speech or articulation issues?					
Have trouble expressing their wants?					
Unable to follow two or three directions given at once?					
Misunderstand meaning of words in relation to movement or body position?					
Movement					
	Often	Some-times	Rarely/ Never	N/A	Comments
Enjoys swings?					
Seem to have good balance?					
Hesitates to avoid climbing?					
Hesitate or have difficulty going down stairs?					
Seem fearful of catching balls?					
Dislike elevators/escalators?					

Walk on toes?					
Jump a lot on beds or other services?					
Bang head on purpose?					
Rock in bed?					
Tend not to alternate between feet going downstairs? (4+ years)					
Like to spin self around?					
Become carsick easily?					
Become upset if head is tilted backwards? (Hair washing)					
Taste and Smell					
	Often	Some-times	Rarely/ Never	N/A	Comments
Tend to explore with smell; deliberately smell objects?					
React defensively or seem overly sensitive to some odors?					
React defensively to the taste and texture of many foods?					
Act as though all food taste the same?					
Have more difficulty eating textured foods compared to smooth foods?					
Prefer crunchy-textured foods?					
Have difficulty eating smooth food with a few lumps?					
Touch					
	Often	Some-times	Rarely/ Never	N/A	Comments
Seem excessively ticklish?					
Become irritated by labels or tags sewn in clothing?					
Prefer to touch rather than be touched					
Strongly dislike haircutting or shampooing?					
Dislike fingernail or toenail cutting?					
Tend to examine objects by touching with hands?					
Have difficulty petting animals, may use too much force?					
Complain if socks aren't on correctly?					
Seem to crave being held or cuddled?					

Dislike being touch unexpectedly?					
Tend to prefer long sleeves and pants regardless of weather?					
Dislike cloth of certain texture?					
Avoid getting hands into paste, finger paints, or messy things?					
Often seem overly active?					
Tend to bump or push others?					
Tend to be more sensitive to pain than other children?					
Become especially bothered by small cuts?					
Tend not to feel pain as much as others?					
Seem oblivious to bruises and heavy falls?					
Tend to remove shoes whenever possible?					
Complain that others often hit or push the child?					
Pinch, bite, or otherwise hurt self?					
Complain about irritating bumps on bed sheets?					
Over-underdress for the temp?					
Overheat easily?					
Strongly dislikes showers? (after age 5)					
Become extremely irritated when splashed with water?					
Mouths objects or clothing frequently?					
Seem overly sensitive to food or water temperature?					
Social					
	Often	Some-times	Rarely/ Never	N/A	Comments
Makes friend easily?					
Tend to prefer to play alone?					
Have a strong desire for sameness or routine?					
Tend to crave attention?					
Seem sensitive to criticism?					
Lack self-confidence?					
Have strong outburst or anger, tantrums?					

Have trouble getting along with other children?					
Tend to be active and aggressive?					
Tend to be quiet and withdrawn?					
Tend to lack carefulness, be impulsive?					
Tend to be relaxed and patient?					
Tend to be intense, easily frustrated?					
Tend to perpetual motion?					
Tend to have difficulty separating from parents?					
Tend to be very set in a routine?					
Prefer the company of adults to children?					
Prefer playing with children who are one or two years younger?					
Seem discouraged or depressed?					
Motor Skills					
	Often	Some-times	Rarely/ Never	N/A	Comments
Bump into things frequently?					
Have difficulty with motor tasks that have several steps?					
Have an awkward grasp with a writing utensil?					
Have poor handwriting?					
Grimace or moves tongue while doing fine motor tasks?					
Seem shaky when doing fine motor tasks?					
Seem weaker than others of same age?					
Frequently grasps objects very tightly?					
Tend to break many objects?					
Drops things easily?					
Tire very easily with physical activity?					
Seem to deliberately fall or tumble?					
Tend to eat in a sloppy manner?					
Find small manipulative activities difficult?					
Prefer playground activities to table activities?					

Prefer table activities to playground activities?					
Perform movements in a slow and plodding fashion?					
Take a long time to do most motor tasks?					
Appear reluctant to participate in sports and games?					
Tend to move in and out of chair with eating or doing work?					
Feel heavier when lifted than anticipated?					
Have flat feet?					
Slump while sitting?					
Have difficulty handling eating utensils?					
Frequently spills liquids?					
Keep mouth open most the time?					
Have trouble chewing?					
Tend to be slow in dressing?					
Tend to be slow in eating?					
Developmental Skills					
	Often	Some-times	Rarely/ Never	N/A	Comments
Turn pages of a book?					
Play with puzzles with single pieces?					
Plays with puzzles with several interlocking pieces?					
Holds arms and legs up for dressing?					
Undress self independently?					
Climb over and on objects?					
Jump with both feet together?					
Ride on tricycle or a large tricycle while pedaling with the feet?					
Build with blocks or other building materials?					
Blow soap bubbles?					
Blow whistles?					
Suck through a straw?					
Draw lines and circles?					
Turns door handles independently?					
Pump self on a swing?					

Blow nose independently?					
Spit out toothpaste after bruising?					
Kick a ball?					
Wipe self after toileting?					
Hop on one foot?					
Color inside lines?					
Manipulate buttons independently?					
Dress self independently?					
Insist on dressing self?					
Cut with scissors?					
Ride a bike with training wheels?					
Ride a bike without training wheels?					
Tie shoes?					
Manipulate snaps, buckles independently?					
Skip with both feet?					
Float on back and stomach in the water?					
Open car doors independently?					
Cut with a knife?					
Jump rope?					
Blow a balloon?					
Blow bubbles with gum?					
Snap fingers?					
Roller or ice skate fluidly?					
Swim using the crawl or other strokes?					

Education History

School: _____ Teacher: _____

Does your child receive any special services?

If enrolled in special education services, has an Individual Educational Plan (IEP) been developed? If yes, please describe most important goals.

What are your child's favorite subjects in school?

What are your child's least favorite subjects in school?

Is your child considered to have difficulty in any of the following?

Reading		Finishing Tasks	
Math		Remembering information	
Spelling		Paying attention	
Handwriting		Organizing work	
Following Directions		Restlessness	

What extra-curricular activities is your child involved in? (gymnastics, soccer, scouts, etc.)

Thank you for taking the time to complete this form. If you feel that there is any other information that would be help our therapists and staff in getting to know your child, please feel free to let us know.

_____

Parent Signature Date