BETH INGRAM THERAPY SERVICES
Speech-Language Therapy ● Occupational Therapy ● Physical Therapy
602 Vonderburg Drive ● Suite 201 ● Brandon, FL 33511
FOR APPOINTMENTS CALL: (813) 653-1149 FAX: (813)654-6644 www.bethingram.com

PEDIATRIC CASE HISTORY

Date: ______/______/______
Person completing this form: __________________________ Relation to child: ____________________

Please fill out this form as completely as possible. The information will help us understand your child's current level of functioning and will aid us in planning appropriate evaluation procedures.

I. CLIENT INFORMATION

________________________________ ______/______/______ ______-______-______ ❑ MALE ❑ FEMALE
PATIENT NAME (LAST, FIRST) DATE OF BIRTH (DOB) SOCIAL SECURITY NUMBER

____
STREET ADDRESS CITY STATE ZIP CODE

(______)______________________________ ______________________________
HOME PHONE E-MAIL ADDRESS

________________________ ____/____/____ (____)____________ ______-______-______
FATHER'S/GUARDIAN'S NAME DATE OF BIRTH CELL PHONE NUMBER SOCIAL SECURITY NUMBER

________________________ ____/____/____ (____)____________ ______-______-______
MOTHER'S/GUARDIAN'S NAME DATE OF BIRTH CELL PHONE NUMBER SOCIAL SECURITY NUMBER

____
Please provide the names and ages of any brothers/sisters of your child

Do you have medical insurance? ❑ YES ❑ NO If yes, which parent is the primary insured? ❑ FATHER ❑ MOTHER

______________________________ (________)______________________________
INSURANCE PROVIDER INSURANCE COMPANY PHONE NUMBER

______________________________ ______________________________
INSURANCE ID NUMBER GROUP NUMBER

______________________________ (________)______________________________
PRIMARY CARE PHYSICIAN PHONE NUMBER

______________________________ (________)______________________________
REFERRED BY PHONE NUMBER

 Revised October 15, 2011

II. CURRENT QUESTIONS AND CONCERNS

Did your child receive a Speech/Language, Physical Therapy, or Occupational Therapy evaluation within the last six months? ❒ NO ❒ YES If yes, Which one? Where? When? ______________________________

Describe your concerns about your child's development: ______________________________

____

Has your child been diagnosed with a medical condition? ❒ NO ❒ YES If yes, please explain? ______________

When did you first notice your child's speech language and/or motor difficulty? ______________

Describe any problems that appear to be a result of your child's difficulty: ______________

____

How do you and your family members react to this problem? ______________________________

Are there any family members or relatives who have or have had speech, language, hearing, or motor problems? ❒ NO ❒ YES If yes, who and what kind? ______________________________

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address? ______________________________

How would you characterize your child's diet? ❒ **Regular** (all foods allowed: no known food allergies or dietary restrictions) ❒ **Regular** (With exceptions: List food allergies/dietary restrictions: ______________)
❒**Pureed** (requiring very little chewing ability) ❒ **Mechanical Altered** (requiring some chewing)

❒ **Advanced** (soft foods that require more chewing ability)

III. SPEECH, LANGUAGE, AND HEARING HISTORY

What language(s) other than English are spoken in the home? ______________________________

What language(s) does the child speak? ______________What is the child's dominant language? ______________

How would you describe the patient's primary method(s) of communication?

❒ Looking at objects ❒ Vocalizing/Grunting ❒ Pointing/Gestures ❒ Single Words ❒ 2-3 Word Phrases ❒ Sentences

Which of the following best describes your child's speech?

❒ Non-verbal ❒ Easy to understand ❒ Difficult for family to understand ❒ Difficult for others to understand ❒ N/A

Did your child begin:
Babbling/Cooing by age 4 months? ❒ YES ❒ NO If no, age in months ________ ❒ N/A
Respond to name/Peek-a-boo by 8 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
Imitating sounds/Using jargon by 12 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
Saying first words by 15 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
Saying 2 words together by 24 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
Using short sentences by 36 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A

Indicate with a check mark any/all areas of difficulty:

❒ Being understood ❒ Making requests ❒ Understanding/Following Directions ❒ Describing events

Has the patient's hearing ever been tested? ❒ YES ❒ NO If yes, Where? When? By whom? What were the results/recommendations? ______________________________

How many ear infections has your child had? ❒ None ❒ 1-2 ❒3-5 ❒ 6-10 ❒ 10 or more

Has your child worn Pressure Equalization Tubes (PE Tubes)? ❒ YES ❒ NO Which ear(s): _________ How Long? ___________

Does your child have a diagnosed hearing impairment? ❒ YES ❒ NO If yes, Where? When? By Whom? Is the loss in one or both ears? What is the level of loss? ______________________________

Does your child wear hearing aids? ❒ YES ❒ NO If yes, which ear(s) are the aids worn? ______________

IV. GENERAL DEVELOPMENT

A. BIRTH HISTORY

Birth Weight: _________________Which pregnancy was this child?___________

Patient was born at gestational age of ________weeks via: ❒ C- Section ❒ Vaginal

If the birth was vaginal, was it completed with ❒ Forceps ❒ Vacuum Extraction ❒ N/A

Were there any complications at birth? How were they resolved? ______________________________________

____

Postnatal: ❒ Jaundice ❒ Required Oxygen ❒ Surgery ❒ Sucking or swallowing problems

B. MEDICAL HISTORY

Are immunizations up to date? ❒ YES ❒ NO Known Allergies:____

List all medications and dosages currently prescribed for the patient (i.e., Amoxicillin, 1 tsp/2x daily): _________

____

Please check the following as they apply to your child:

❒ Low birth weight
❒ 3 or More Ear Infections
❒ Seizure Disorder
❒ Surgeries
❒ Hearing Loss
❒ Allergies (Sinusitis, food, etc)
❒ Syndrome: ______________
❒ Hyperactivity/ADD
❒ Cleft Lip
❒ Cleft Palate
❒ Asthma
❒ Head injury
❒ Diabetes
❒ Cerebral Palsy
❒ Gastric Reflux
❒ Tonsillitis

C. MOTOR DEVELOPMENT

Does your child seem overly awkward, uncoordinated or clumsy? ❒ YES ❒ NO

Does your child lose their balance or fall easily? ❒ YES ❒ NO

Does your child display hand preference? ❒ YES ❒ NO If so, which hand? ❒ Left ❒ Right

Did your child:
- Hold his/her head up by 4 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- Sit alone by 6 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- First crawl by 12 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- First walk alone by 16 months ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- Potty-trained by 3 years ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- Fed self by 2 years ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- Use scissors by 3 years ❒ YES ❒ NO If no, age in months ________ ❒ N/A
- Grasp crayon/pencil (thumb and finger) by 3 yrs ❒ YES ❒ NO If no, age in months ________ ❒ N/A

Indicate with a check mark any/all areas of difficulty:

❒ Zippers/Buttons ❒ Hopping/jumping ❒ Dressing ❒ Handwriting ❒ Lacing/tying shoes ❒ Walking backwards

❒ Lifting head while on stomach
❒ Rolling over
❒ Sitting Alone
❒ Creeping on hands and knees
❒ Bringing hands together at midline
❒ Copying Shapes
❒ Accepting weight into legs
❒ Standing at furniture
❒ Standing Alone
❒ Bearing weight on arms
❒ Transferring objects from hand to hand
❒ Cutting on a line around a shape
❒ Pulling to sit/stand
❒ Throwing ball overhand
❒ Walking/Running/Jumping
❒ Walking up/down steps
❒ Building tower with blocks
❒ Balancing/hopping on one foot

D. EDUCATIONAL HISTORY

Age at entrance to school: ______ years ______ months ❒ Preschool ❒ Home Daycare ❒ Kindergarten

Current school: ________________________________ Grade: _____________ Grades Repeated: ___________

Type of classroom ❒ Regular ❒ Exceptional Student Special Program Does your child have an IEP? ❒ YES ❒ NO

Indicate with a check mark any/all areas of difficulty:

❒ Reading	❒ Math	❒ Spelling	❒ Handwriting	❒ Writing sentences
❒ Attention	❒ Organization	❒ Study Habits	❒ Complex directions	❒ Rhyming

III. SOCIAL/EMOTIONAL DEVELOPMENT

Please check as they apply to your child:

❒Overly active	❒ Underactive Very shy/Overly quiet	❒ Eating Difficulties Interrupted/ unusual eating habits
❒ Poor eye contact	❒ Poor Memory	❒ Sleeping Difficulties
❒Destructive/Aggressive	❒ Plays alone for reasonable amount of time	❒ Avoids group play/Prefers to play alone
❒ Friendly/Outgoing	❒ Easily frustrated	❒Falls/trips frequently
❒ Interrupted/ unusual sleeping habits	❒ Pretend Play	❒Imitates actions/gestures/speech
❒ Appropriate turn taking skills	❒ Appropriate use of objects	❒ Difficulty with transitions
❒ Difficulty separating from parent	❒ Difficulty concentrating	❒ Plays with toys appropriately

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CONSENT FOR MEDICAL TREATMENT

I give permission for ____ to receive treatment at Beth Ingram Therapy Services.
PATIENT'S NAME (FIRST, LAST)

Such care may include, but not be limited to diagnostic evaluations and procedures considered advisable in the diagnosis, treatment and course of care. I understand that he/she will be expected to follow treatment plans that are mutually agreed upon between the treating clinician, primary care physician, and me.

I certify that I am the legal guardian and that I can exercise all parental rights for said child.

____ ____________________

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

Attachments: Financial Policy
Attendance Policy
Authorization to Release Protected Health Information