Therapy Hut, Inc.
895 Willow Tree Circle, Ste.100, Cordova, TN 38018
Phone Number: 901-309-5219
Fax Number: 901-309-5265

Case History Form

Dear Parent/Guardian,

We are honored to have the opportunity to evaluate/treat your child. Please take the time to fill out this case history form. We realized that it is lengthy. We ask that you complete this form with as much information as possible. This information will be used in the diagnostic process to assist us in providing the most effective treatment plan possible.

Name of Patient: _____ Date of Birth: _____

Preferred Phone Number: _____ Name of present school or daycare: _____
Grade: _____ Preferred Time for Evaluation and Therapy: _____

In which Therapy Hut programs are you interested?
_____ Occupational Therapy ____ Physical Therapy ____ Speech/Language Therapy
_____Wellness Program

Birth History

*Adopted? _____Yes _____No

*Were there any complications during the pregnancy? _____Yes _____No
If yes, please explain: _____
_____

*Were there any complications during the delivery? _____Yes _____ No
If yes, please explain: _____
_____

*Were there any complications before the baby went home? _____ Yes _____No
If yes, please explain: _____

*Length of Mother's stay in hospital after delivery: _____

*Length of Child's stay in hospital after delivery? _____

Family History

Mother's Name: _____
Father's Name: _____
With whom does your child reside? _____

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Sibling's Names and Ages:

_____
_____
_____

*Do, or did, any family members have any medical, mental, learning or significant disabilities that might be relative to the case? _____ Yes _____ No

If yes, please provide the following information:

Relationship Difficulty

_____
_____

Medical History

*Does your child have any medical diagnosis? _____ Yes _____ No

If yes, please list any previously diagnosed conditions.

_____
_____

*Does your child present with a hearing loss? _____ Yes _____ No

If yes, what type of amplification is used?

_____
_____

*Has your child ever had Ear Infections? _____ Yes _____ No

If yes, how many ear infections and at what age? How were they treated?

_____
_____

*Has your child required PE tubes? _____ Yes _____ No

If yes, at what age were PE tubes required and how many sets has your child had?

_____
_____

*Does he/she presently have PE tubes? _____ Yes _____ No

If your child has not been previously diagnosed with a hearing loss, do you suspect a hearing problem? _____ Yes _____ No

*Does your child wear glasses? _____ Yes _____ No

If your child does not wear glasses, do you suspect a vision problem?

_____ Yes _____ No

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*Describe any other serious Illnesses/ Injuries
_____
_____
_____

*Describe any surgery and resulting recommendations:
_____
_____
_____

*Is your child currently on any medications? _____ Yes _____ No
If yes, please list the medications and reason for prescription:
_____
_____

*Please list any allergies your child has or possibly has:
_____
_____

*Is your child on a special diet? _____ Yes _____ No
If yes, please explain: _____
_____

*Has your child received any of the following special services?
Psychological _____ Yes _____ No
Physical Therapy _____ Yes _____ No
Occupational Therapy _____ Yes _____ No
Speech/Language Therapy_____ Yes ____ No
Hearing Services _____ Yes _____ No
Other _____ Yes _____ No

- If yes to any, please explain when they stopped or if they still receive services, also please list the contact information._____
_____
_____

Behavior and Social History

*How long will your child pay attention to preferred activities (T.V., games, etc.)?
_____ 20 minutes _____ 10 minutes _____ 5 minutes _____ less

*How long will your child pay attention to non-preferred activities?
_____ 20 minutes _____ 10 minutes _____ 5 minutes _____ less

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*What are non-preferred activities for your child?
_____
_____
_____

*How does your child interact with adults?
_____ Easily _____ Average _____ Reluctant

*How does your child interact with children?
_____ Easily _____ Average _____ Reluctant

*Describe your child's interests (play activities, favorite toys, places to go):
_____
_____
_____

*Does your child present with any self stimulation behaviors? ___ Yes___ No
If yes, please describe: _____
_____
_____

*Does your child present with any violent tendencies (e.g. biting, hitting)
_____ Yes _____ No If yes, please describe:
_____
_____

Fine and Gross Motor Developmental History

*Child sat alone between the ages of 6 and 8 months _____Yes _____No

*Child crawled/creped between 7-10 months _____ Yes _____ No

*Child walked alone between the ages of 12 and 15 months _____Yes _____No

*Was your child hyperactive _____Yes _____No

*Does your child roll to his/her side_____Yes _____ No

*Does your child roll on his/her back _____ Yes ____No?

Check all that apply:

*My child _____ Runs, _____ Jumps, _____ Hops on one leg, _____ Skips

*Does your child trip or fall more than usual_____ Yes _____ No

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*Does your present with a hand dominance _____ Yes _____ No
If yes, which hand is dominant? _____

Check all that apply:

*My child has difficulty _____ dressing, _____ grooming, and _____ toileting

*Are there any other fine/gross motor difficulties the Therapy Hut Staff should be aware of to better serve your child?_____
_____
_____

Speech and Language Development History

*Child said first words between the ages of 12 and 18 months _____Yes _____No

*Child used two words together (i.e., "Mommy go," or "Want drink") by 24 moths
_____Yes _____ No

*During the first year, was your child unusually quiet and/or made few sounds other than crying?
_____Yes _____ No

*How much does the child talk at home? _____ Average _____ none _____ A few words

*Does the child use gestures with words? ____ Yes _____ No

*Does the child mainly use gestures? _____ Yes _____ No

*Are there languages other than English spoken in the home? ____ Yes _____ No If yes, what language(s)? _____

*Does the child speak or understand other languages? _____ Yes _____ No
If yes, what language(s)? _____

*How well does the family understand the child's speech?
_____ Easily understood
_____ Understood if the listener knows the topic
_____ Words understood now and then
_____ Completely unintelligible
_____ Gestures understood

*Did your child's speech/language learning ever seem to stop? ____Yes____ No
If yes, please explain: _____
_____

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*Does your child have difficulty understanding directions or conversations?
_____ Yes _____ No

*Does your child respond to the following?
His/Her Name: _____ Yes _____ No
Verbal Instructions: _____ Yes _____ No
Instructions with gestures: _____ Yes _____ No
Gestures Alone: _____ Yes _____ No
Soft Noises: _____ Yes _____ No
Loud Noises: _____ Yes _____ No
Vibrations: _____ Yes _____ No

*How do you communicate with your child?
_____
_____

*How does your child make his/her needs known to you?
_____
_____

*Please describe your main concerns regarding your child's speech and language?
_____
_____

*Please describe the long-term goals you would like to see your child achieve through speech/language therapy: (Feel free to use the back of this page)
_____
_____

*Has your child received speech and language therapy in the past?
_____ Yes _____ No
If yes, what was the outcome? Were there any recommendations?
_____
_____
_____

Feeding Development

*Did your child grow at a normal rate? _____Yes _____ No

*Did your child exhibit typical suckle/sucking ability? _____ Yes _____ No

*Does your child present with excessive loss of liquid during sucking or drinking?
_____ Yes _____ No

*Is your child able to feed him/herself? _____ Yes _____ No

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*Did your child have difficulty transitioning to pureed food? _____ Yes _____ No

*Did your child have difficulty transitioning to solid food? _____ Yes _____ No

*Did your child present with difficulty chewing? _____ Yes _____ No

*Did your child present with difficulty swallowing? _____ Yes _____ No

*Does your child dislike a variety of textures? _____Yes _____ No
If yes, please explain what your child does not like:
_____

*Does your child have esophageal reflux? _____ Yes _____ No
If yes, what medications are given? _____

*What are your child's favorite foods? _____
_____

*Does your child present with difficulty controlling oral secretions? ___ Yes __ No

*Does your child put inedible objects in his/her mouth? _____ Yes _____ No
If yes, does he/she do this constantly or on occasion? Are you concerned about your child possibly choking? _____
_____

Academic History

*Describe any problems your child is having in school: _____

---

*How does the child feel about daycare/school?
_____
_____

*Is the child frequently absent? _____ Yes _____ No

*Has the child ever failed a grade, been held back, or skipped a grade?
_____ Yes _____ No

*What does your child's teacher say about his or her academic performance?
_____
_____

*What does your child's teacher say about his or her classroom behavior?
_____
_____

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*What is your child's typical performance in these areas? (Please circle the appropriate choice)

Reading	Below Average	Average	Above Average
Mathematics	Below Average	Average	Above Average
Language Arts	Below Average	Average	Above Average
Writing	Below Average	Average	Above Average
Spelling	Below Average	Average	Above Average
Science	Below Average	Average	Above Average
Social Studies	Below Average	Average	Above Average

That completes the Case History Form. Thank you again for completing this. We are looking forward to working with you and your family. If there is any other information that we have failed to obtain or information you would like us to know about your child, please provide that information in the following area: