PM & R Pediatric Rehab Services
Children's Case History Questionnaire

Southwest General
Partnering with University Hospitals

CONFIDENTIAL

Name of person completing form ________________________ Date ____________

Please fill out this form as completely as you can. The information you provide will enable us to better assist you and your child. Thank you.

I. Identifying Information

Child's Name ______________________ Birthdate __________ Age ________

Address ____

Referring Physician ____

Location ______________ Phone __________ Fax __________

Child's Pediatrician ____

Location ______________ Phone __________ Fax __________

Psychology ______________ Gastroenterologist ______________

Ear/Nose/Throat ______________ Orthopedic ______________

Neuro ______________ Other ______________

Mother's Name ______________________ Phone Home __________

Address ______________________ Work __________

______________________ Cell __________

Occupation: ______________________

Father's Name ______________________ Phone Home __________

Address ______________________ Work __________

______________________ Cell __________

Occupation: ______________________

Who has legal custody of this child?

Name ______________________ Relationship ______________

Brothers & Sisters:

Names	Age	Sex	Grade in School	Speech, Hearing/Medical Problems
1.				
2.				
3.				
4.				
5.				

II. Statement of the Problem

- ☐ Gross Motor Skills ____
- ☐ Fine Motor Skills ____
- ☐ Speech & Language Skills ____
- ☐ Feeding & Swallowing Skills ____

What would you like your child to accomplish in therapy? ______________________

III. Pregnancy/Birth History

Length of pregnancy:_________________

What illnesses/accidents occurred during pregnancy? ____

List any medications taken during pregnancy: ____

____

Reason for Medication: ____

Check all that apply to birth:

☐ Forceps ☐ Bruising ☐ Vacuum ☐ Oxygen
☐ Blue or Jaundiced ☐ Blood Transfusion ☐ Child Hospitalized

Describe ____

____

Weight of child at birth: _________________________

Describe any problems following birth *(swallowing, sucking, feeding, sleeping, health abnormalities):*

____

____

Have any of these problems continued?____

____

IV. Medical History

At what ages did any of the following illnesses, problems, or operations occur?

Problems	Age	Problems	Age
Adenoidectomy		Gastroesophageal Reflux	
Allergies		Headaches	
Asthma		Head Injuries	
Chronic Colds		High Fevers	
Seizures		Neurological, i.e. Cerebral Palsy	
Dental Problems		Orthopedic Procedures	
Earaches/Infections		Pneumonia	
Frequency Duration:		Sinus	
Encephalitis		Tonsillectomy	
Failure to Thrive			

List any medications your child is taking and what they are for: ______________________________________

____

V. Speech / Language / Vision and Hearing History

At what age did the following occur?

Babbling & cooing __________________Two to three words combined ____________________

First words spoken __________________Sentences spoken ______________________________

Does your child use speech: ☐ Frequently ☐ Occasionally ☐ Never

Does your child prefer to use speech or gestures? ____

Which does your child prefer to use?

☐ Complete sentences ☐ Phrases ☐ One or two words ☐ Sounds

How well can your child be understood by:

Parents ☐ Good ☐ Fair ☐ Poor
Siblings/playmates ☐ Good ☐ Fair ☐ Poor
Relatives/strangers ☐ Good ☐ Fair ☐ Poor

How well does your child understand what is said to him? ☐ Good ☐ Fair ☐ Poor

V. Speech / Language / Vision and Hearing History cont'd

Vision & Hearing History

	Tested	Result	Within the last year?
Vision	☐ Yes ☐ No	☐ Normal ☐ Impaired	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	☐ Normal ☐ Impaired	☐ Yes ☐ No

Does your child wear hearing aids? ☐ Yes ☐ No Glasses? ☐ Yes ☐ No

VI. Therapy and Educational History

School your child attends ______________________________ Phone ______________

School District ______________________ Teacher's Name ______________________

Therapy in school		Therapist's Name	Therapist's Phone
OT	☐ Yes ☐ No		
PT	☐ Yes ☐ No		
SLP	☐ Yes ☐ No		

Has your child received therapy in the past? ______________________________

Is there a history of speech problems in the family? If so, did they receive treatment?______________

____

____

VII. Daily Behavior

Does your child play alone or with others? ____________Ages of playmates: ______________

Does your child get along well with other children? __________Adults? ______________

Does your child have difficulty concentrating? ______________________________

Describe any emotional or behavioral problems: ______________________________

____

How do you handle your child's behavior? ______________________________

____

What does your child avoid doing? ______________________________

____

What does your child enjoy or show interest in? *(favorite toys / activities / TV characters)* ______________

____

Does your child follow a predictable routine each day? ☐ Yes ☐ No

How does your child handle changes in his routine? ______________________________

____

What is the most challenging aspect in raising your child? ______________________________

____

Do you need help contacting someone to help manage your child's behavior? ☐ Yes ☐ No

Please add any additional information you feel will help us in understanding your child: ____________________

____

____

____

____

____

____

List any questions you or others have about your child.

1. ____
2. ____
3. ____
4. ____
5. ____

We would appreciate copies of most recent reports from Health Care providers and / or school IEP's.

Thank you for providing us with this important information.

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Communication Authorization

I authorize the therapist treating my child ________________________________ to discuss the treatment provided or issues related to treatment with the following people:

- ☐ (Step) Mother: ____
- ☐ (Step) Father: ____
- ☐ Grandmother: ____
- ☐ Grandfather: ____
- ☐ Aunt / Uncle: ____
- ☐ Nanny / Babysitter: ____
- ☐ Caregiver / Nurse: ____
- ☐ Sibling: ____
- ☐ Significant Other: ____
- ☐ Other: ____

The Therapist may **NOT** share information with the following people:

____

____

____

Parent / Guardian Signature: ____

Date: _____________________