



303 SW 18th Street Suite 1 & 3 Bentonville, AR 72712
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CASE HISTORY

Client/Family Information:

Client Name:	
Client Date of Birth:	
Name of Parent(s):	
Address:	
Phone number(s):	
Email Address:	
Client lives with: (Please list names and ages of all family members living in the home such as: parents, siblings, etc)	
Name:	Age:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
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Emergency Contact Information *(other than parent/guardian):*

Name	Relationship to Client	Phone Number
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Authorized Individuals for Communication & Pickup *(Individuals we may discuss therapy with OR release your child to):*

1. Name: _____ Relationship: _____ Phone: _____ Discuss care? <input type="checkbox"/> Yes <input type="checkbox"/> No Pick-up? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Name: _____ Relationship: _____ Phone: _____ Discuss care? <input type="checkbox"/> Yes <input type="checkbox"/> No Pick-up? <input type="checkbox"/> Yes <input type="checkbox"/> No

Referral Information:

Referral Source:
Primary Care Physician:
Reason for Referral:
Describe any concerns related to your child's speech, language, feeding, fine motor, sensory, and/or gross motor development:

Has your child received therapy before? <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other Where/When: _____
Is your child currently receiving therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type & location: _____

Birth History:

Gestational age: _____ weeks
Prematurity: _____ mos _____ weeks _____ days
Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
Birth weight:
After birth, did your child spend time in the hospital (ex-NICU) for medical reasons? If so, please explain:
Explain any serious conditions or complications during pregnancy, labor, and/or delivery:

Developmental Milestones:
Please indicate approximate age your child achieved the following:

Sat alone unsupported:
Crawled:
Walked:
Said first word(s):
Said first two-word combination(s):
Potty Trained:

Medical Information:

Diagnoses (if any): _____
Allergies: _____
Medications:
Name: _____ Purpose: _____ Dose: _____
Name: _____ Purpose: _____ Dose: _____
Medical History (check all that apply):
<input type="checkbox"/> Frequent ear infections – How many/what years? _____

<input type="checkbox"/> PE tubes – Date placed: _____ <input type="checkbox"/> Surgeries – List: _____ <input type="checkbox"/> Seizure history <input type="checkbox"/> Asthma <input type="checkbox"/> Heart conditions <input type="checkbox"/> Other: _____
Hearing: Passed newborn hearing screen? <input type="checkbox"/> Yes <input type="checkbox"/> No Latest hearing test? _____ Location: _____
Vision: Vision evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Location: _____
Specialists seen (current or past): <input type="checkbox"/> Neurologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Nutritionist/Dietician <input type="checkbox"/> Orthopedist <input type="checkbox"/> Developmental Specialist <input type="checkbox"/> Audiologist <input type="checkbox"/> Vision Therapist Other: _____

Feeding History:

Early feeding difficulties (nursing/bottle)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain: _____
Trouble transitioning to baby foods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble transitioning to table foods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current diet age-appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, explain: _____
Picky eater or problem feeder? <input type="checkbox"/> Yes <input type="checkbox"/> No
Concerns about feeding/eating? _____
Current weight: _____

Educational Information:

Does your child attend daycare/preschool/school? <input type="checkbox"/> No <input type="checkbox"/> Yes
School name: _____
Grade: _____
School services currently received:
<input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Behavioral/psychological services <input type="checkbox"/> Other: _____
IEP or 504 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

Oral Motor History:

Does your child do the following:

Brush teeth or allow teeth to be brushed?
Use a pacifier or suck thumb?
Drink from a sippy cup or open cup?
Blow bubbles from a wand?
Blow out candles?
Give kisses by rounding lips?
Chew on non-food items?

Drool?
Breathe through nose or mouth?
Show awareness of food or drink on face?

Motor, Sensory & Daily Functioning

Check any difficulties your child has:

<p>Sensory & Regulation</p> <ul style="list-style-type: none"><input type="checkbox"/> Difficulty with transitions<input type="checkbox"/> Sensitive to clothing or textures<input type="checkbox"/> Seeks excessive movement/touch<input type="checkbox"/> Frequently bumps/trips/falls<input type="checkbox"/> Overly active or low energy <p>Fine Motor</p> <ul style="list-style-type: none"><input type="checkbox"/> Scribbling/drawing<input type="checkbox"/> Using scissors<input type="checkbox"/> Independent hand washing<input type="checkbox"/> Consistent hand dominance<input type="checkbox"/> Shoe tying <p>Gross Motor</p> <ul style="list-style-type: none"><input type="checkbox"/> Kicking or throwing a ball<input type="checkbox"/> Catching a ball<input type="checkbox"/> Pedaling a tricycle/bike<input type="checkbox"/> Skipping<input type="checkbox"/> Balance issues
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Daily Routines & Strengths

Describe your child's daily behavior, strengths, and interests:
Challenges or behaviors we should be aware of: