Reaching the Potential of each Precious Child

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Parent Questionnaire - Case History Form

Confidential

Please fill in this form as completely as possible.
If you have any questions or need clarification, please feel free to contact us at (805) 474 - 6811

Name of Child : ______________________________

Address : ______________________________
Street   City   State   Zip Code

Home Phone Number : ______________ **Parent's Work Phone :** ______________

Date of Birth : ____________ **Natural or Adopted :** ____________ **Present Age :** ____________

Who can we thank for References to our office : ______________________________

Address : ______________________________

(1) Parent / Partner / Caregiver : ______________ **Birth Date :** ______________

Occupation : ______________________________

(2) Parent / Partner / Caregiver : ______________ **Birth Date :** ______________

Occupation: ______________________________

Will a different caregiver be bringing the child to therapy? (circle) **Yes** **No**

If yes, whom? ______________________________

May we discuss treatment with this person? (circle) **Yes** **No**

Legal Relationship of Parents to Child (please check) :

Biological Parent : Parent / Partner / Caregiver ________ Parent / Partner / Caregiver ________

Adoptive Parent : Parent / Partner / Caregiver ________ Parent / Partner / Caregiver ________

Step - Parent : Parent / Partner / Caregiver ________ Parent / Partner / Caregiver ________

Foster Parent : Parent / Partner / Caregiver ________ Parent / Partner / Caregiver ________

Relative : ______________________________

All persons living in the home:

Name	Age	Relation to Child	Present Grade or Highest Grade Completed

Parental Concerns : Please describe the major concerns you have for your child. List your concerns in the order of importance to you.

1. (most important) ____

2. ____

3. ____

4. ____

5. ____

Medical History :

Child's Pediatrician or Family Doctor ____

Address ____
Street City State Zip Code

Vital Signs Height__________ Weight ___________ Hand strength R__________ L__________

Cognitive/ Perceptual ☐ Intact ☐ Minimum ☐ Moderate Impairment ☐ Maximum Impairment

Communication ☐ Verbal ☐ Non-verbal ☐ Unable to communicate ☐ Relies on primary care for communication needs

Balance / Coordination ☐ Normal ☐ Deficits in the following:
Static Position___________________ ☐ Good ☐ Fair ☐ Poor ☐ Zero
Dynamic Position_______________ ☐ Good ☐ Fair ☐ Poor ☐ Zero

Muscle Tone :

Location:	Flacid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Right

Head
Trunk
U. E.
L.E.

☐ ☐ ☐ ☐

Sensation Intact Impaired Absent Location ____________________

Pregnancy :

While Pregnant, did child's mother have any of the following:

	Yes	No
German measles	_______	_______
Anemia	_______	_______
Diabetes	_______	_______
Kidney Problems	_______	_______
High Blood Pressure	_______	_______
Any severe emotional problems	_______	_______
Vaginal Infection or bleeding	_______	_______
Have a high fever	_______	_______
Smoke cigarettes	_______	_______
Drink alcohol	_______	_______

What medication did child's mother take during pregnancy?
(include vitamins and iron): ____________________

Has child's mother ever experienced a miscarriage? ____________________

If yes, did miscarriage precede or follow the pregnancy with this child? ____________________

Birth :

Was the child born: Early __________ Late __________ Or, on time? __________

Was the child born by C-section? Yes __________ No __________
If Yes, please give reason for
c-section:____________________

What was the baby's birth weight? ____________________ Length? ____________________

What was the baby's condition at birth? ____________________

____

Has the child ever had the following :

	Yes	No
Eye or vision problems	_______	_______
Ear or hearing problems	_______	_______
Allergies	_______	_______
Peanut allergy	_______	_______
Asthma	_______	_______
Seizures	_______	_______
Head injury	_______	_______
Anxiety	_______	_______
Anemia	_______	_______
Vomiting spells	_______	_______
Frequent diarrhea	_______	_______
Frequent colds	_______	_______
Strain on urination	_______	_______
Meningitis	_______	_______
Depression	_______	_______

Has child had any other health problem that would affect this
Clinic (Not listed above) ____________________

____

Please specify special diet of the child :____________________

What are your feelings about providing chewing gum during fine-motor activity time? ____________________

Does child take medication on a regular basis? Yes ________ No ________

Please list medication taken and amount: ____

____

Does child receive any other therapies: ____

____
____

Development and School History

Development :

At what age did child first:

Sit alone	____________________	Feed self finger foods	____________________
Crawl (hands & feet)	____________________	Speak first real words	____________________
Stand alone	____________________	Speak first real sentences	____________________
Walk well	____________________	Become completely toilet trained	____________________

School History :

Is child currently enrolled in a school program? Yes _________________ No _______________

If yes, please answer the following:

School Name : ____

Address : ____

Grade (if applicable) : ____

Has child been evaluated by a school diagnostic team? Yes ______________ No _______________

If yes, when was the evaluation completed? ____

Please describe the child's performance at school. What subject does he/she do well in ; what subjects does he/she have difficulty with? ____

____

____

Does child receive any special services to help him/her at school? ________________________________

If yes, please describe : ____

____

____

Social -Emotional Development :

Does child exhibit behaviors at home or school that concern you? Yes ____________ No ____________

If yes, please describe the behaviors that concern you : ____

____

____

What methods are used to discipline the child? ____

____

Are these methods effective? Yes ______________ No ______________

What does child like to do to occupy his/her time? ____

____

Does child have regular playmates or friends? Yes ___________ No _____________

Person completing application : ________________________ **Relation to child :** ________________________

Parent / Guardian Signature : ___________________________________ **Date :** _______________________