Case History Form

Part A ~ Identifying Information		
Child		
Child's Name		
Date of Birth (Y/M/D)	Age	Gender ☐ Male ☐ Female
Case ID #	Manitoba Medical #	Personal Medical #
Parents		
Mother's Name	Occupation	Work Phone
Father's Name	Occupation	Work Phone

Other Children in Family		
Name	Age	Developmental History
Name	Age	Developmental History
Name	Age	Developmental History
Name	Age	Developmental History

Physician
Name

Part B ~ Pregnancy/Birth History

This is our ☐ biological child. ☐ foster child. ☐ adopted child.

Age of mother at child's birth: _____

Child's birth weight: _____

Length of pregnancy: _____

Describe any complications during pregnancy (i.e., injury, accident, disease, etc.):_____

_____

Birth condition: ☐ normal ☐ premature ☐ prolonged delivery

Were there any unusual problems at birth? ☐ Yes ☐ No

Explain:_____

_____

_____

Were drugs used during labour/delivery? ☐ Yes ☐ No

Describe:_____

_____

Please identify any of the following which applied to your infant during the first week of life:

- ☐ Child needed oxygen
- ☐ Child jaundiced
- ☐ Child placed in special nursery
- ☐ Child remained in hospital following mother's discharge
- ☐ Child needed blood transfusion
- ☐ Other. Please describe:_____

_____

Part C ~ Developmental History

At what age did your child:

Sit alone without support? _____ Crawl? _____ Walk? _____

Dress/undress independently? _____ Feed him/herself? _____

Become toilet trained? _____

Does your child:

Have difficulty chewing or swallowing? ☐ Yes ☐ No

Drool? ☐ Yes ☐ No

Have difficulty maintaining balance? ☐ Yes ☐ No

Part D ~ Medical History

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, how often? _____

Describe any serious illness that your child has had. _____

_____

Have any of these illnesses been accompanied by a high fever? ☐ Yes ☐ No

If yes, please describe. _____

_____

Please check any of the following that your child has experienced:

- ☐ Seizures
- ☐ Frequent respiratory infections
- ☐ Serious head injury or accident
- ☐ Allergies. Please list: _____
- ☐ Tonsillitis
- ☐ Headaches
- ☐ Asthma
- ☐ Chronic colds
- ☐ Other. Please describe: _____

If your child is taking any medication, please give the name of the medication, describe its purpose, and give the date started. _____

_____

_____

_____

Part E ~ Educational History

Does your child attend nursery school/daycare? ☐ Yes ☐ No

If yes, how many times per week? _____ At what age did he/she start? _____

Has daycare/nursery school expressed any concerns about your child's communication abilities?

☐ Yes ☐ No If yes, please describe: _____

_____

_____

Part F ~ Daily Behaviour

Does your child:

Sleep well?	☐ Yes	☐ No	Play with others?	☐ Yes	☐ No
Eat well?	☐ Yes	☐ No	Get along with other children?	☐ Yes	☐ No
Play alone?	☐ Yes	☐ No	Get along with adults?	☐ Yes	☐ No

Age of your child's playmates _____

Does your child have difficulty concentrating? ☐ Yes ☐ No

Would you describe your child as:

☐ average ☐ overactive ☐ under active
☐ happy ☐ unhappy

Is your child easy to manage? ☐ Yes ☐ No

What are his/her favorite play activities?_____

_____

I agree to have my child assessed by the:

Speech/language pathologist ___ ***Occupational Therapist*** ___ ***Physiotherapist*** ____

As a participant in the PROMISE YEARS Therapy Program I understand and agree to the following:

Service Delivery:

- That the PROMISE Years Therapy Program provide services according to an indirect service model;
- That my child shall receive services as deemed necessary by the therapist; and
- That I/we will follow home-based programming suggestions made by the therapist as appropriate.

Attendance Policy:

- That clients who do not attend, nor call to cancel scheduled appointments, will be discharged from the caseload after two consecutive and/or three cumulative missed appointments; and
- That clients who frequently call to cancel their appointment will be discharged at the therapist's discretion.

_____ _____

Parent(s)'/Guardian(s)' Signature ***Date***

Thank you for completing this form

This personal information, or personal health information, is being collected under the authority of PROMISE Years and will be used for educational purposes or to ensure the health and safety of the student.

It is protected by the Protection of Privacy provisions of The Freedom and Protection of Privacy Act and The Personal Health Information Act. If you have any questions about the collection, contact your local school division Access and privacy Coordinator

Speech, Language and Hearing History

1. Describe, in your own words, your concerns:

2. When did you first become concerned?

3. Describe any changes noticed in your child's speech since that time:

4. How does your child feel about his/her speaking ability?

5. Do you feel that your child is affected by his/her speaking ability?

Please answer the following questions about your child.

Did your child babble or coo during the first six months of life? ☐ Yes ☐ No

At what age did your child say his/her first words?_____

Has your child continued to add new words since he/she began to talk? ☐ Yes ☐ No

Did language learning ever appear to stop for a period of time? ☐ Yes ☐ No

Does your child talk ☐ frequently? ☐ occasionally? ☐ rarely?

What is your child's main mode of communication (i.e., speaking, gesturing, making sounds, etc)

How many different meaningful words does your child use? ☐ 0-10 ☐ 10-50 ☐ 50+

If your child talks, list, in the child's own words, two or three things he/she said today.

_____

_____

Does your child make sounds incorrectly? ☐ Yes ☐ No

If yes, which ones?_____

_____

Is your child's speech ☐ easily understood? ☐ understood if you know the topic?
☐ understood occasionally? ☐ completely unintelligible?

Does your child ever hesitate or "get stuck" on words? ☐ Yes ☐ No

Explain:_____

_____

Does your child understand what you say to him/her? ☐Yes ☐No

Can he/she follow simple commands? ☐ Yes ☐ No

Has your child ever been seen by a speech/language pathologist? ☐Yes☐ No

If yes, when and by whom?_____

_____

What percentage of English is spoken in the home? _____

Has your child ever been seen by an audiologist? ☐Yes ☐No

If yes, when and by whom?_____

_____

Have you ever had any concerns about your child's hearing? (Please specify.)_____

_____

Has your child ever had ear infections? ☐ Yes ☐ No

If yes, how many_____

How were they treated? ☐ medically ☐ placement of tubes

Does your child wear a hearing aid? ☐ Yes ☐ No

If yes, is the hearing aid worn in ☐ the right ear? ☐ the left ear?
☐ both ears? ☐ No

Physiotherapy History

Describe in your own words, your concerns: _____

_____

_____

When did you first become concerned? _____

_____

_____

Has your child's physical abilities changed since that time? _____

_____

_____

_____

Answer these questions about your child

Does your child walk independently? ☐ Yes ☐ No

If yes at what age did they start _____ If no, will they walk with assistance ☐ Yes ☐ No

What type of assistance? _____

Does your child crawl? ☐ Yes ☐ No

If yes, at what age did they start _____

Is your child able to sit independently? ☐ Yes ☐ No

Does your child lose their balance frequently? ☐ Yes ☐ No

If yes approximately how many times per day _____

Does your child have difficulties with:

☐ Walking ☐ Jumping ☐ Running

☐ Hopping ☐ Ball skills (throwing and catching)

☐ Coordination ☐ Balance

Does your child have tight muscles in their arms of legs? ☐ Yes ☐ No

Does your child walk on their toes? ☐ frequently ☐ seldom ☐ never

Does your child seen to lose control of their body at times? ☐ Yes ☐ No

Does your child use both arms and legs equally (excluding hand dominance) ☐ Yes ☐ No

Is your child able to keep up with other children of a similar age ☐ Yes ☐ No

Occupational Therapy History

Describe in your own words, your concerns_____

_____

_____

When did you first become concerned?_____

Answer these questions about your child:

Does your child use their ☐ right hand? ☐ left hand? ☐ both?

Is your child oversensitive to specific sensations? ☐ Yes ☐ No

(Example – bothered by lights, noises, feel of clothing, picky eater)
Please describe _____

_____

_____

Is your child undersensitive to specific sensations? ☐ Yes ☐ No
(Example – doesn't notice when called, clumsy, overly forceful etc)
Please describe

_____

_____

_____

Is your child independent with their self care activities (eating, dressing, toileting, sleeping)
Yes ☐ No☐
If no please describe concerns

_____

_____

_____