



THERAPY SOLUTIONS OF GEORGIA, INC.

3615 BRASELTON HIGHWAY · SUITE 103 · DACULA, GEORGIA 30019-5907

CASE HISTORY QUESTIONNAIRE

Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____ / ____ / ____
(First) (MI) (Last)

Male Female Name of Informant: _____ Relationship: _____
(Person completing this questionnaire)

Email Address: _____ Phone Number: _____

Who referred you to this clinic? _____

A. PREGNANCY/BIRTH

1. Were there any complications during pregnancy? (Please explain.) Yes No
2. Were there any complications during labor? (Please explain.) Yes No
3. Did you carry your child full term? Yes No
- If no, how many weeks? _____ weeks
4. Was your child delivered by vaginal delivery or cesarean delivery? _____
5. Did your child leave the hospital with his/her mother? Yes No
- If no, how long did he/she remain in the hospital? _____
6. Were any follow-up doctor visits required? (Please explain.) Yes No
7. What was the child's birth weight? _____ lbs. _____ oz.
8. During infancy was your child very irritable? Yes No
9. Difficult to soothe? Yes No
10. Difficult to get to sleep? Yes No
11. Difficult to cuddle/hold? Yes No

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Patient Name: _____

3. Has your child ever received a modified barium swallow study? Yes No

Date: _____/_____/_____

What were the results and recommendations?

Is your child safe for oral intake? Yes No

4. Does your child receive tube feedings? Yes No

What is the feeding schedule and amount of intake?

D. MILESTONES

At What age did your child achieve the following milestones?

- | | |
|--|---|
| 1. Cooing Babbling? _____ Yrs. _____ mos. | 5. Sit independently? _____ Yrs. _____ mos. |
| 2. First word? _____ Yrs. _____ mos. | 6. Crawling? _____ Yrs. _____ mos. |
| 3. Two words together? _____ Yrs. _____ mos. | 7. Walking? _____ Yrs. _____ mos. |
| 4. Sentences? _____ Yrs. _____ mos. | 8. Toilet training? _____ Yrs. _____ mos. |

Do you have any other developmental concerns about your child? (i.e. motor skills, etc.) _____

E. FAMILY HISTORY

1. List the members of your household and their relation to your child. Include ages of siblings.

Name _____ Relation _____ Age _____	Name _____ Relation _____ Age _____
Name _____ Relation _____ Age _____	Name _____ Relation _____ Age _____
Name _____ Relation _____ Age _____	Name _____ Relation _____ Age _____



Patient Name: _____

<p>2. Is there a history of speech, language, or developmental delay in your family? (Please explain.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is English the primary spoken language in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what is? _____</p> <p>4. Are there additional languages spoken in the home? (Please list.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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F. EDUCATIONAL/THERAPY HISTORY

1. Does your child attend school? Yes No
If yes, please answer the following:

What school does your child attend? _____

What grade is your child in? _____

What kind of classroom is your child placed in? _____

Does your child have an IEP (Please provide copy)/**receive any support services?** Yes No

Does your child receive therapy at school? (Please list types/frequency) Yes No

Describe your child's performance at school. _____

Has your child ever repeated a grade? Yes No

2. Has your child ever been evaluated or followed by any of the following specialist? (Please provide a copy of testing results if available.)

<input type="checkbox"/> Psychologist or Psychiatrist	<input type="checkbox"/> Audiologist	<input type="checkbox"/> Craniofacial Team
<input type="checkbox"/> Developmental Pediatrician	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Nutritionist
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Orthodontist
<input type="checkbox"/> ENT	<input type="checkbox"/> Speech/Swallowing Therapist	

3. Does your child receive any other private therapy at this time? (What type/Where?) Yes No _____

4. Please list any programs your child has participated in and the results (e.g. The Listening Program, Earobics, ABA, Behavior Intervention):

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G. ORAL HYGIENE/FEEDING

1. Was your child bottle or breast fed? Bottle Breast

2. Did he/she experience any early feeding problems? (Please explain.) Yes No

3. Is your child able to eat a variety of food consistencies? Yes No

4. Is your child on a special diet (Please explain.) Yes No

5. Can he/she drink liquids and eat food without coughing, spitting, gagging, or choking? Yes No

6. Does your child present with any of the following:

Picky Eater Over Eating Poor Appetite

Drooling Difficulty Chewing

7. Does your child feed him/herself? Yes No

8. Is your child able to drink from a "sippy" cup? Yes No

9. Is your child able to drink from an open cup? Yes No

10. Is your child experience loss of liquid when drinking? Yes No

11. Does your child brush his/her teeth or allow brushing? Yes No

12. Does your child suck his/her thumb? Yes No

13. Does your child use a pacifier? Yes No

14. Does your child have other oral habits? Yes No
(Please explain.)

15. Does your child visit a dentist? Yes No

16. Has your child had any dental problems? Yes No
(Please explain.)

17. Does your child experience frequent laryngitis/hoarseness? Yes No

18. Do you have any other oral concerns? Yes No

H. SOCIAL SKILLS/BEHAVIOR

1. Is your child exposed to children his/her own age? Where? Yes No

2. Does your child exhibit difficulties interacting with peers? (Please explain.) Yes No

3. Are there things that your child tends to fear/avoid? (Please explain.) Yes No

4. Does your child tend to play with things by lining or piling them up? Yes No

5. Does your child demonstrate any sensory difficulties (e.g. doesn't like to be touched, doesn't like to touch sticky things, only eats certain foods, sensitive to teeth brushing)? Yes No

6. How does your child spend free time at home?

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Patient Name: _____

7. Does your child give up on something because he/she feels it is too hard? Yes No

How frequently does this occur?

What types of things are these?

8. Is your child aware of or frustrated by communication difficulties? Yes No

9. Does your child have behaviors that seem puzzling or different than other children? Yes No

10. Which of the following behaviors does your child exhibit?

- | | | |
|--|---|--|
| <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Difficulty calming | <input type="checkbox"/> Difficulty switching from one activity to another |
| <input type="checkbox"/> Unwilling to try new activities | <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Destructive/aggressive |
| <input type="checkbox"/> Unable to play independently | <input type="checkbox"/> Easily distracted/short attention span/impulsive | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Separation difficulties | <input type="checkbox"/> Unusually active | <input type="checkbox"/> Self-abusive behavior |
| <input type="checkbox"/> Easily frustrated/upset | | |

11. What type of behavior strategies have you tried to manage his/her behavior?

12. Are these techniques usually successful? Yes No

I. MISCELLANEOUS

1. What prompted you to refer your child for a therapy evaluation? _____

2. What kinds of things have you tried to help your child overcome their problems and what has been their effectiveness? _____

3. What are your goals and expectations for therapy? _____



Patient Name: _____

Speech-Language Therapy Patients

J. ARTICULATION

1. How much of your child's speech do you understand? _____%

2. Please rate your child's speech intelligibility:
 Excellent Good Fair Poor Unintelligible

3. How much of your child's speech do strangers understand? _____%

4. How does your child react when he/she is not understood?

5. What sounds does your child have difficulty producing?

K. LANGUAGE—AGES BIRTH TO 3

1. Does your child understand *you* when you talk to him/her? Yes No

2. Does your child follow simple 1-2 step instructions? Yes No

3. Does your child retrieve objects upon request? Yes No

List examples: _____

4. Does your child point to objects/pictures on command? Yes No

5. Does your child enjoy stories read to him/her? Yes No

How long will he/she attend to a story? _____

6. Does your child play with age-appropriate toys appropriately? Yes No

7. How does your child currently communicate? _____

8. Does your child ask for help when needed? Yes No

9. Does your child use words to name things around the house and/or people? Yes No

List examples: _____

10. How many words is your child using now? _____

If less than 50, please complete the attached word sheet.

11. Does your child put multiple words together when communicating? Yes No

12. How does your child express his/her wants and needs?
 Pointing Single words Conversation

13. Does your child respond correctly to yes/no questions? Yes No

17. Does your child experience frequent laryngitis/hoarseness? Yes No

L. LANGUAGE—AGES 3 AND ABOVE

1. Does your child use age appropriate sentence structure most of the time? Yes No

2. Does your child use correct grammar? Yes No

3. Is your child able to express ideas clearly? Yes No

4. Does your child respond correctly to who/what/when/where/why questions? Yes No

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5. Is your child able to answer questions following a story? Yes No

6. Is your child reading on grade level? Yes No

7. Does your child understand what he/she has read? Yes No

8. Does your child experience difficulty with writing? Yes No

9. Does your child understand classroom lessons? Yes No

10. Does your child follow multiple step directions? Yes No

M. AUDITORY PROCESSING

1. Has your child been diagnosed with an auditory processing disorder? Yes No

2. Has your child been diagnosed by an audiologist with a central auditory processing disorder? Yes No

3. Do you have concerns regarding your child's ability to process information (e.g. following directions, remembering details, phonological skills)? Yes No

O. HEARING IMPAIRED CHILDREN

1. At what age was your child's hearing loss identified? _____

2. Describe your child's hearing loss.

3. Does your child wear hearing aids? Yes No

4. Does your child have a cochlear implant? Yes No

Which side?
 Left Right Both

When was it placed? _____

5. How often does your child see an audiologist? _____

What is his/her name and phone number? _____

N. BILINGUAL CHILDREN

1. What is the primary language spoken in the home? _____

2. How much exposure does your child have to English and to your native language?

3. Does your child have older siblings who speak English? Yes No

4. Does your child speak English? Yes No

5. Does your child understand English? Yes No

6. Does your child speak their native language? Yes No

7. Does your child understand their native language? Yes No

8. Are your child's language skills more advanced in one language versus the other? Yes No

9. How does your child's language skills compare to other children who have learned English as a second language?



Patient Name: _____

Occupational Therapy Patients

P. VISUAL PROCESSING

1. Does your child become easily distracted by visual stimulation? Yes No
2. Does your child prefer to play in the dark or dimly lit areas? Yes No
3. Does your child tend to draw some number/letters backwards? Yes No
4. Does your child blink at bright lights or seem irritated at them? Yes No
5. Does your child have difficulty discriminating shapes, colors, etc.? Yes No
6. Does your child have difficulty following objects with his/her eyes? Yes No
7. Does your child avoid or have difficulty with eye contact? Yes No

Q. AUDITORY PROCESSING

1. Does your child have difficulty maintaining or copying rhythms? Yes No
2. Does your child at times not seem to understand what is said? Yes No
3. Does your child seem overly sensitive to sounds? Yes No
4. Does your child become distracted by background noises such as fluorescent lights, fans, refrigerators, etc.? Yes No
5. Does your child have trouble remembering what is said? Yes No
6. Is your child unable to follow 2 or 3 step directions given at once? Yes No
7. Does your child misunderstand the meaning of words in relationship to movement or body position? Yes No

R. MOVEMENT PROCESSING

1. Does your child enjoy swings? Yes No
2. Does your child like being tipped upside down? Yes No
3. Does your child hesitate or avoid climbing on playground equipment? Yes No
4. Does your child hesitate or have difficulty going down stairs? Yes No
5. Does your child seem fearful of catching balls? Yes No
6. Does your child dislike elevators or escalators? Yes No
7. Does your child walk on his/her toes? Yes No
8. Does your child seem to crave jumping or crashing? Yes No
9. Does your child bang his/her head on purpose? Yes No
10. Does your child like to spin him/herself around? Yes No
11. Become upset when his/her head is tilted backwards as in hair washing? Yes No
12. Does your child tend to be in perpetual motion? Yes No

S. TASTE AND SMELL

1. Does your child tend to explore with smell? Yes No
2. Does your child react defensively or seem overly sensitive to some odors? Yes No
3. Does your child react defensively to the taste or texture of many foods? Yes No
4. Does your child lick, suck, or chew on non-food items (past 18 months)? Yes No

T. TOUCH

1. Does your child become irritated by tags in the back of shirts? Yes No
2. Does your child strongly dislike haircutting or shampooing? Yes No
3. Does your child strongly dislike fingernail or toenail cutting? Yes No
4. Does your child have difficulty controlling the amount of force used when petting animals or playing with younger children? Yes No
5. Does your child complain if socks are not on correctly? Yes No
6. Does your child dislike being touched unexpectedly? Yes No
7. Does your child tend to prefer either long or short sleeved and pants regardless of the weather? Yes No
8. Does your child dislike clothes of certain textures? Yes No
9. Does your child avoid touching messy things such as glue, finger paint, etc.? Yes No
10. Does your child tend not to feel pain as much as others? Yes No
11. Does your child mouth objects or clothing frequently? Yes No

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