THERAPY SOLUTIONS OF GEORGIA, INC.
3615 BRASELTON HIGHWAY· SUITE 103· DACULA, GEORGIA 30019-5907

CASE HISTORY QUESTIONNAIRE

Date: _____

PATIENT INFORMATION

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

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

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	

Patient Name: _____

B. Medical History

1. Has your child had any serious injuries or major illnesses? (Please explain.)	☐ Yes ☐ No	
2. Does your child have any known allergies? (Please list.)	☐ Yes ☐ No	
3. Is your child taking any medications? (Please list.)	☐ Yes ☐ No	
4. Is your child taking any dietary supplements? (Please list.)	☐ Yes ☐ No	
5. Does your child have a history of ear infections?	☐ Yes ☐ No	
How many?	_____	
6. Did your child pass the newborn hearing screening?	☐ Yes ☐ No	
7. Has your child completed any additional hearing test?	☐ Yes ☐ No	
8. Does your child have tubes or has he/she had tubes?	☐ Yes ☐ No	
When were they inserted?	____/____/_____	
Doctor's name:	_____	
When were they removed?	____/____/_____	
9. Has your child received an adenoidectomy?	☐ Yes ☐ No	
10. Has your child received a tonsillectomy?	☐ Yes ☐ No	
11. Has your child completed a vision screening?	☐ Yes ☐ No	
When ____/____/_____	☐ Pass ☐ Fail	
12. Do you have concerns about your child's hearing/vision? (If so, please explain.)	☐ Yes ☐ No	
13. Does your child experience any sleeping difficulties?	☐ Yes ☐ No	
14. Has your child received any medical diagnoses? (Please list.)	☐ Yes ☐ No	

C. Medically Fragile Children

1. Is there anything we need to know while your child is in our care? (i.e. seizure protocol, etc.)	☐ Yes ☐ No	
2. Does your child have any health problems which may negatively impact therapy? (Please explain.)	☐ Yes ☐ No	

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

Patient Name: _____

2. Is there a history of speech, language, or developmental delay in your family? (Please explain.) ☐ Yes ☐ No

3. Is English the primary spoken language in the home? ☐ Yes ☐ No

If no, what is? _____

4. Are there additional languages spoken in the home? (Please list.) ☐ Yes ☐ No

F. EDUCATIONAL/THERAPY HISTORY

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

What school does you 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.)

- ☐ Psychologist or Psychiatrist
- ☐ Developmental Pediatrician
- ☐ Neurologist
- ☐ ENT
- ☐ Audiologist
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Speech/Swallowing Therapist
- ☐ Craniofacial Team
- ☐ Nutritionist
- ☐ Orthodontist

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):

Patient Name: _____

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? (Please explain.) ☐ Yes ☐ No
15. Does your child visit a dentist? ☐ Yes ☐ No
16. Has your child had any dental problems? (Please explain.) ☐ Yes ☐ No
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?

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?

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

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?

_____

_____

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_____

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

Patient Name: _____

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

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?

_____

_____

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? _____

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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

Patient Name: _____

U. Motor Skills

1. Does your child bump into things frequently?	☐ Yes ☐ No
2. Does your child have difficulty with motor skills that have several steps?	☐ Yes ☐ No
3. Does your child have an awkward grasp with a pencil or crayon?	☐ Yes ☐ No
4. Does your child have poor handwriting?	☐ Yes ☐ No
5. Does your child seem shaky when doing fine motor tasks?	☐ Yes ☐ No
6. Does your child seem weaker than others his/her age?	☐ Yes ☐ No
7. Does your child frequently grasp objects tightly?	☐ Yes ☐ No
8. Does your child seem to deliberately fall?	☐ Yes ☐ No
9. Does your child appear reluctant to participate in sports and games?	☐ Yes ☐ No
10. Does your child tend to move in and out of a chair when doing work?	☐ Yes ☐ No
11. Does your child have flat feet?	☐ Yes ☐ No
12. Does your child tend to slump while sitting?	☐ Yes ☐ No
13. Does your child have difficulty handling eating utensils?	☐ Yes ☐ No

V. Developmental Skills

1. Can your child turn the pages of a book?	☐ Yes ☐ No
2. Can your child put together puzzles with single pieces?	☐ Yes ☐ No
3. Can your child put together puzzles with interlocking pieces?	☐ Yes ☐ No
4. Can your child ride a tricycle?	☐ Yes ☐ No
5. Can your child draw lines and circles?	☐ Yes ☐ No
6. Can your child pump him/herself on a swing?	☐ Yes ☐ No
7. Can your child color inside lines?	☐ Yes ☐ No
8. Can your child dress him/herself independently?	☐ Yes ☐ No
9. Can your child manipulate snaps, buttons, and zippers?	☐ Yes ☐ No
10. Can your child cut with scissors?	☐ Yes ☐ No
11. Can your child tie his/her shoes?	☐ Yes ☐ No

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