Manatee Memorial Hospital

Manatee Memorial Hospital
Outpatient Pediatric Therapy

Pediatric Case History Form

The Manatee Memorial Hospital Outpatient Pediatric Therapy Team requests this information for the purpose of completing your child's evaluation. We ask that you complete this form and bring it with you to the initial evaluation. Thank you for your cooperation. We look forward to seeing you and your child.

General Information:

Name of child: _____ Date of birth: _____

Child lives with: _____ Relationship: _____

Telephone: (home) _____ (work) _____ (cell) _____

Marital status of parents: _____

Mother's name: _____ Profession: _____

Father's name: _____ Profession: _____

Language spoken in the home: _____ Language spoken by child: _____

Please list other member of the household:

Full Name	Relationship to Child	Age

Who is your child's pediatrician? _____

Does your child currently receive any Therapies? ☐ PT ☐ OT ☐ Speech ☐ Other

Name of facility, if applicable: _____

Agencies your child is known to:

☐ Children's Medical Services	☐ Developmental Services	☐ Social Security
☐ Easter Seals	☐ All Children's Hospital	☐ Medicaid
☐ Blake Medical Center	☐ Manatee Memorial Hospital	☐ Early Steps Program
☐ Shriner's Hospital	☐ Tampa General Hospital	☐ Other _____

Does your child go to school? ☐ No ☐ Yes - If "Yes", what school and grade? _____

Who is your child's teacher? _____

Is your child in any special type of classes? _____

Does you child participate in any organized sports? ☐ No ☐ Yes - If "Yes", what sports and where?

_____

Prenatal History

Complications during pregnancy: ☐ No ☐ Yes - If 'Yes" please explain: _____

_____

Restrictions during pregnancy: ☐ No ☐ Yes - If "Yes" please explain: _____

Birth weight: _____ Length: _____ ☐ Full Term ☐ Premature (_____ weeks)

Type of delivery: ☐ Natural ☐ Caesarean section

At what hospital? _____

Complications at Birth: ☐ Trouble breathing ☐ Jaundice ☐ Blue color ☐ Birth injuries
☐ Irregular heart rate ☐ Other: _____

Please explain any checked areas" (use back of page if necessary) _____

_____

How long did your child remain hospitalized after birth? _____

At what hospital? _____

Postnatal History

Has your child been diagnosed with any of the following? Please check all that apply.

☐ Seizures	☐ Asthma	☐ Frequent fevers	☐ Sinus problems
☐ Heart problems	☐ Cerebral Palsy	☐ Meningitis	☐ Chest Infections
☐ Breathing Trouble	☐ Lung Problems	☐ Muscular Dystrophy	☐ Head Injury
☐ Multiple Sclerosis	☐ Cancer	☐ Cystic Fibrosis	☐ Diabetes
☐ Pneumonia	☐ Bronchitis	☐ Infant feeding difficulties	

☐ Ear Infections - How many? _____ Treatment type: ☐ Antibiotics ☐ PE Tubes

☐ Broken Bones - What bones and when? _____

☐ Other: _____

Are your child's immunizations up to date? ☐ No ☐ Yes - If "No", please list reason: _____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes - If "Yes", where and for what reason? _____

_____

Has your child ever had a serious accident? _____

Has your child ever had an operation? _____

Are there any medical precautions that need to be taken when treating your child ☐ No ☐ Yes

If "Yes", please explain: _____

Is your child currently taking any medications? (describe type and reason) _____

_____

Does your child have any known food allergies or intolerances? (describe) _____

_____

Has your child ever had an ear/hearing examination? ☐ No ☐ Yes - When? _____

Where? _____ Results? _____

Has your child had a vision examination or treatment? ☐ No ☐ Yes - When? _____

Where? _____ Results? _____

Please list any special equipment your child uses for daily activities, such as glasses, hearing aids, braces, wheelchair, feeding tube, etc., _____

_____

Diagnostic testing (X-ray, MRI, CT scan, X-ray swallow test, etc.)? _____

_____

Developmental Information

At what age did your child first do the following:

Developmental Skill	Age when your child first did skill	Comments or concerns about skill
Lift head while on tummy		
Roll Over		
Sit Alone		
Crawl/Creep		
Pull to Stand		
Walk with Support		
Walk Alone		
Run		
Climb Steps		
Walk Down Steps		
Held Bottle alone		
Drink From Cup		
Use a Spoon		
Babble		
Say Mama/Dada		
Speak in Phrases		
Speak in Sentences		
Toilet Trained		
Dress Self.		

Speech/Language

Have you noticed any speech difficulties? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

Please describe your child's speech: _____

_____

Do other people have difficulty understanding your child's speech? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

_____

Does your child appear to have difficulty understanding what you say or following directions? ☐ No ☐ Yes

If "Yes", please explain: _____

_____

Does you child rely on gestures to make needs known? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

Do you think your child's speech has changed in the last 6 months? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

_____

Play Skills

What are your child's favorite play things? _____

_____

What does your child do with their favorite toys? _____

_____

Who does the child prefer to play with? _____

_____

What activities does your child least enjoy? _____

_____

Are there any things your child avoids or is fearful of? _____

_____

How long does your child play with one toy? _____

Sleeping History

What is your child's average bed time? _____ When do they wake up? _____

Do they have a change in sleep schedule on the weekends? ☐ No ☐ Yes - If "Yes", please provide: _____

_____

What activities does your child enjoy in the afternoon? _____

What activities does your child enjoy/do after dinner? _____

What does you child do right before bedtime? _____

Does your child ever doze off while: Watching TV? ☐ No ☐ Yes

Riding in the car? ☐ No ☐ Yes

At the table/while eating? ☐ No ☐ Yes

Please describe all those with "Yes" responses: _____

_____

Is your child an "early bird" or a "night owl"? _____

Does your child sleep with a nightlight on? _____

Does your child snore? _____

Does your child complain of being too hot or too cold at night? _____

Does your child perspire heavily at night? _____

Does your child crave or require another person to be with them to sleep? _____

_____

Any other concerns/comments about sleep? _____

Eating/Feeding

Have you noticed any of the following in your child? Check all that apply.

- ☐ History of failure to gain weight or poor weight gain
- ☐ Persistent ear infections
- ☐ Vomiting/spitting up during/after feeding
- ☐ Wet/gurgly voice quality
- ☐ Increased oral secretions, congestions or drooling
- ☐ Difficulty latching on
- ☐ Frequent coughing, choking, gagging during/after feeding
- ☐ Stressed or scared to eat or drink
- ☐ History of pneumonia, bronchitis or frequent upper respiratory infections
- ☐ Eczema
- ☐ Rash/red cheeks/severe diaper rash
- ☐ Picky eater

Please explain items checked: _____

_____

Has your child had an x-ray swallowing test? ☐ No ☐ Yes - If "Yes", please provide: _____

Date: _____ Facility: _____

Results: _____

Has your child been seen by a Gastroenterologist/GI doctor? ☐ No ☐ Yes - If "Yes", who? _____

Were any studies completed and what were the results? _____

_____

How long does it take your child to eat a meal? _____

Does your child have any meal time games, habits, routines, rituals? ☐ No ☐ Yes - If "Yes", please describe:

_____

_____

_____

Where does your child sit for the majority of meals? _____

What does you child sit in during meal time? _____

Who is the primary feeder of your child? (Please check all that apply)

☐ Mother ☐ Father ☐ Daycare ☐ Sibling ☐ Self ☐ Other _____

What does your child drink from (please check all that apply):

☐ Breast

☐ Bottle: Brand _____ Nipple _____

☐ Sippy Cup: hard spout/soft spout with a plug/without a plug

☐ Straw

☐ Open rim cup

☐ Tube feeding: continuous feeding/bolus feeding/bolus push/ hydration and medications only

Please list your child's current formula and/or any supplements: _____

_____

Please list foods your child will ALWAYS eat: _____

_____

Please list foods your child will NEVER eat: _____

_____

Does your child have any food allergies? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

Please provide any other feeding concerns that you have that were not addressed above: _____

_____

_____

Behavior/Social Development/Activities of Daily Living

During your child's life, have there been any changes in the family situation (parent's martial status, death, frequent move)? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

How does your child get along with other children? _____

_____

Do you have any difficulties managing your child's behavior? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

_____

Does your child have any special fears (dog, darkness)? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

Are there things that your child does that you think are unusual? _____

_____

Has he/she ever been to a nursery, day care or preschool center? ☐ No ☐ Yes - If "Yes", please list facilities attended and indicate length of time spent at each: _____

_____

_____

Have you noticed any differences when comparing your child to other children of the same age? ☐ No ☐ Yes - If "Yes", please explain: _____

_____

What does your child like? _____

Dislike? _____

Please indicate with a (+) the items that you feel are strengths in your child and use a (-) to identify the factors that you feel are weaknesses in your child.

_____ Response to smells and tastes
_____ Response to touch
_____ Response to visual stimuli
_____ Response to movement
_____ Response to sounds
_____ Response to eating
_____ Ability to manage physical/motor requirements of play/school activities
_____ Ability to manage thinking requirements of play/school activities
_____ Self-feeding
_____ Dressing
_____ Toileting
_____ Grooming
_____ Fine-hand coordination
_____ General activity level
_____ Attention span
_____ Social skills

Is there anything else that you would like us to know at this time that you feel can help us provide better services for your child?