



## Child Case History Form

Welcome to Auburn TLC! In order to help us achieve our mission of providing the highest quality treatment for your child, please fill out this form as accurately as possible. We look forward to working with you and your child.

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

### Prenatal and Birth History

Mom's age at birth \_\_\_\_\_ Dad's age at birth \_\_\_\_\_

Length of Pregnancy \_\_\_\_\_ Child's weight at birth \_\_\_\_\_

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Breech

Any illnesses or accidents experienced during pregnancy? ☐ Yes ☐ No

If yes, please provide details, including any medications used. \_\_\_\_\_

\_\_\_\_\_

Was your child's delivery normal? ☐ Yes ☐ No If no, please provide details \_\_\_\_\_

\_\_\_\_\_

Did your child experience any health problems during or after birth? (health, swallowing, sucking, feeding, sleeping) ☐ Yes ☐ No If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

### Medical History

Has your child ever had surgery? ☐ Yes ☐ No When? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has your child ever been hospitalized for a serious illness? ☐ Yes ☐ No

If yes, indicate when and explain:

\_\_\_\_\_

Has your child ever experienced any of the following? Check all that apply and please indicate age of occurrence:

ILLNESS	YES	AGE	ILLNESS	YES	AGE
Adenoidectomy			Headaches		
Allergies			Head injury		
Asthma			Heart problems		
Blood Disease			High fevers		
Chickenpox			Influenza		
Chronic Colds			Measles/Mumps		
Croup/whooping cough			Neuromuscular Disorders		
Dental problems			Rheumatic Fever		
Ear Infections			Pneumonia		
Ear tubes inserted for ear infections			Other _____		
Encephalitis/Meningitis					

### Speech and Language Development

At what age did your child speak his or her first word? \_\_\_\_\_

Did it ever seem like your child started losing words? ☐ Yes ☐ No

How does your child primarily communicate? ☐ Pointing ☐ Gestures ☐ Grunting ☐ Crying

☐ 2 -3 Word Phrases ☐ 2-4 Word Sentences ☐ Sentences longer than 4 words

When your child uses words, what percentage of his/her speech is understood? \_\_\_\_\_

Does your child understand the following? ☐ His/Her Name ☐ Names of Body Parts ☐ Object Labels

☐ Names of Family Members ☐ Simple Directions ☐ Who/What/When/Why/How Questions

### Gross Motor Development

Please indicate the ages when these skills were observed:

Milestone	Age at which achieved	Still an area of concern
Holding head up while lying on stomach		
Rolling over		
Sitting up unassisted		
Crawling		
Pulling to stand		
Cruise along furniture		
Standing unassisted		
Walking unassisted		

**Fine Motor Skills Development**

Please indicate the ages when these skills were observed:

Milestone	Age at which achieved	Still an area of concern
Reaches and grasps objects		
Transfers objects from one hand to the other		
Grasping objects with index finger and thumb		
Feeds self with fingers and/or utensils		
Stacks blocks		
Copies drawn lines and cuts with scissors		
Counts to 5 using fingers		
Uses knife for cutting		
Correctly holds a pencil/crayon		
Writes own name		
Completes simple puzzles		

**Area(s) of Concern**

What are your concerns about your child's development? \_\_\_\_\_

\_\_\_\_\_

When did you notice these concerns? \_\_\_\_\_

Has your child previously received services for these concerns? ☐ Yes ☐ No

If yes, when and where: \_\_\_\_\_

\_\_\_\_\_

**Education History**

Does the child attend day care or school? ☐ Yes ☐ No

Name of Day Care or School: \_\_\_\_\_ Grade (if attending school): \_\_\_\_\_

Teacher's Name \_\_\_\_\_

Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No If yes, please provide a copy of the IEP.

Does the child have any siblings? ☐ Yes ☐ No (If yes, please list below)

Name	Age	Sex	History of speech, language, hearing or medical problems?

Is there a family history of speech or language problems? ☐ Yes ☐ No

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

Other language(s) spoken in the home? \_\_\_\_\_

Please list any diagnoses your child has:

\_\_\_\_\_

Is your child currently taking any medications? ☐ Yes ☐ No (If yes, please indicate below):

Medication	How often?	For what purpose?

**Please list any allergies your child has, especially food allergies:**

\_\_\_\_\_

### Behavior

Please check 'YES' for all that apply to your child:

BEHAVIOR	YES	Describe
Eating problems or picky eater		
Sleeping problems		
Doesn't play appropriately with toys		
Short attention span		
Overactive		
Underactive		
Cries a lot		
Doesn't follow directions		
Easily upset		