Webster Therapy Center

Putting the Pieces Together

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PATIENT CASE HISTORY

Date: ___________________________

Child's Name: ____ Sex: __ DOB: ______________________ Age: _________

Address: ____ Preferred Contact #: ________________

(Street) (City & State) (Zip)

Email: ____

Physician (Name & Address): ____

Who referred you to this clinic? ____

Description of main concern: ____

____

____

Name of responsible party for payment of charges: ______________________________________

Name of Insurance Company: ____

PARENTS:

Child is living with: Biological Parents ______ Parent & Stepparent ______ One Parent Alone ______ Adoptive Parents ______ Foster Parents ______ Other ______

Parent's Marital Status: Married _______ Separated _______ Divorced _______ Widowed _______ Single _______

PARENT #1:

Name: ____ DOB: _____________________________

Address: ____

Cell Phone: ____________________________________ Business Phone: _____________________________

Place of Employment: ______________________________________ Occupation: _____________________

PARENT #2:

Name: ____ DOB: _____________________________

Address: ____

Cell Phone: ____________________________________ Business Phone: _____________________________

Place of Employment: ______________________________________ Occupation: _____________________

CHILDREN: List ALL children in order.

Name	Sex	Age	Grade in School	Any Problems of Child

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Others living in home: ____
Dominant language in home: ____
List any speech or hearing problem on either side of the family: ______________________________

____

What is your child's main concern or diagnosis? ____

____

When was problem first noticed? ______________________ By Whom? ______________________
What do you believe this clinic can do for your child? ____

BIRTH HISTORY

Was pregnancy normal? _______ Any illness during pregnancy? _______ If so, what? ______________________
Special diet or medication during pregnancy? ____
How many gestational weeks was the pregnancy? ____
Was delivery head first, feet first or caesarean? ______________________ Birthweight ______________________

Did the baby have any of the following at birth or postnatally:
Trouble starting to breathe or cry? _________ Yellow? _________ Blue? _________
Sleepy? _______ Convulsions? _________ Sucking or feeding difficulty? ______________________ Birth defects? _________

MOTOR DEVELOPMENTAL HISTORY

Overall motor development appears to be within normal limits... Yes ________ No ________

State age when child first…

sat alone _________ fed self with spoon _________ toilet trained - night _________ completed shape puzzle _________
walked alone _________ fed self with fork _________ laced beads _________ stopped drooling _________
rode tricycle _________ toilet trained - day _________ scribbled on paper _________ stopped mouthing objects _________
rode bicycle _________

Does child use… right hand? ________________ left hand? _______________ both? ___________________

SPEECH DEVELOPMENTAL HISTORY

Overall speech development appeared to be within normal limits… Yes ________ No ________

During the first year did child make much sound other than crying? ______________________________
At what age did child say first words? ________________ What were they? ______________________________
Did child keep adding words once child started to talk? ______________________________
At what age did child…
begin to name people and objects? ______________________________
combine words into small sentences (e.g., "Want drink" or Me out?") ____________________
use more complete short sentences? ________________________
Did speech learning ever seem to stop for a period? _____________ If so, describe: ______________________________

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Does child understand what you say? ____

Does child seem to be aware of a speech difference? __________ If so, describe: ______________________

____

What efforts have been made to help child talk better? (Include previous speech therapy and treated by whom) ____________

____

Has there been a change in child's speech in last six months? _________ If so, describe the change: ______________

____

Has child ever talked better than he/she does now? ____________________________________

SENSORY DEVELOPMENT

Check all that apply

Gags/vomits on food ______ Difficulty in large groups ______ Dislikes swings, slides, climbing ______

Sensitive to sounds ______ Dislikes tags or certain textures of clothes ______ Continuously on the move ______

Dislikes being messy ______ Falls easily or stands too close to others ______

MEDICAL HISTORY

Has your child had an audiological (hearing) evaluation? __________ When? ______________________

By whom? ______________________________ Results: ______________________________

Has child had a serious illness or head injury? __________ If so, explain: ______________________

____

When? ____________ Lasting effects of injury/illness: ______________________________

Has child had any of the following?(Check all that apply)

Convulsions, spasms or seizures _____ Nervous trouble _____ ADD/ADHD _____ Vision difficulties _____

Serious high fevers _____ Behavioral issues _____ Speech difficulties _____ Glasses/Contacts _____

Swallowing/feeding problems _____ Allergies _____ Hearing difficulties _____

Clumsiness or weakness _____ Asthma _____ Middle ear infections _____

Other ____

If you checked any of the above, please explain: ____

Has child had an EEG? (Brain wave test) _________ When? ____________ Where? ______________

Results: ____

Other tests: ____

What medication and dosage is child taking? ____

What surgery has child had and when? ____

Is child in good health at this time? ____

Are there any physical restrictions: ____

Health of other family members: ____

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SCHOOL

Name of present school/preschool: ______________________________ District: ____________

Grade: __________ Teacher(s): ______________________________

School performance: Superior ______ Average ______ Poor ______

Has child repeated a grade? ______ If so, which? ______________________________

Any school concerns? (describe in detail): ______________________________

____

What is child's attitude toward school? ______________________________

SOCIAL

Describe child's interests: ______________________________

Is child a follower or leader of his/her age group? ______________________________

What unusual fears does child have? ______________________________

Is child "nervous?" __________ How does child show it? ______________________________

Describe any behavioral problems: ______________________________

OTHER INFORMATION

Has child received or is receiving the services of other professionals (physician, counselor, therapist (speech or occupational) etc.)?

Professional's Name	Address	Date Seen

Have you scheduled any additional testing or services for your child? If yes, when and where. ______________________

____

Name of person completing this form: ______________________________

Relationship to patient: ______________________________

Financial Agreement

_____I understand that I am responsible for evaluation and treatment charges incurred through this clinic and any charges not paid by my insurance company if assignment of benefits is accepted by Webster Therapy Center. If insurance is billed by Webster Therapy Center, I agree to pay my copay and/or deductible and percentage at the time service is rendered. **In the event insurance does not pay as expected, I understand that I am responsible for the balance due.**

Acknowledgement of Review of *Notice of Privacy Practices*

_____I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Consent for Treatment

_____I authorize Webster Therapy Center to evaluate and/or provide treatment.

SIGNATURE/DATE OF PARENT(S) OR GUARDIAN:

____ ________________________

Parent/Guardian Date

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