General Cast History ST/OT/PT - Sans Consent Forms - English

CLIENT GENERAL CASE HISTORY

1. Client information:

Client's First Name: _____ Client's Middle Name: _____ Client's Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Non-binary Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

How Did You hear About Us / Referred By: _____

Your Preferred Service Location:
☐ 209 Cherry St, Milford, CT
☐ 29 Federal Rd. Danbury, CT

2. Please include any accommodations/accessibility needs for the client or family member here:

_____

3. Physician Information

Name of Pediatrician or PCP: _____ Pediatrician Group _____

Phone: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

INSURANCE FORM

4. PRIMARY MEMBER/POLICY HOLDER INFORMATION

Primary Insurance Company: _____ Member ID / Policy #: _____ Group Number: _____

Client Relationship to Insured:
○ Parent ○ Guardian ○ Client/Self

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

5. Do you have additional/secondary insurance?

- ○ Yes
- ○ No

6. SECONDARY POLICY HOLDER INFORMATION

Do you have any additional insurance? ○ Yes ○ No

If yes, please complete the following:

Secondary Insurance Company: _____

Member ID / Policy #: _____

Group Number: _____

Client Relationship to Insured:
○ Parent ○ Guardian ○ Patient/Self

Policy Holder's Name: _____

Policy Holder's Phone #: _____

Policy Holder's Date of Birth: _____

Policy Holder's Gender: ○ Female ○ Male

Policy Holder's Street Address: _____

City: _____

State: _____

Zip Code: _____

Policy Holder's Employer/School: _____

7. Please provide images of your insurance card(s), front and back.

ALLERGY ALERT FORM

8. Please list any known allergies the client may have (i.e. to foods, medicines, environmental agents) and describe the client's response to contact with the applicable allergen(s).

	Allergic to?	Reaction
1		
2		
3		

9. Primary Emergency Contact

Name: _____

Phone: _____

Emergency Contact Relationship: _____

10. Secondary Emergency Contact

Name: Phone:

Emergency Contact Relationship:

11. Please describe immediate action to be taken in case of contact with allergen(s).

BACKGROUND & FAMILY INFORMATION

12. Parent/Guardian information:

Parent/Guardian Name: Occupation:

Parent/Guardian Name: Occupation:

13. Where/Who does the child live with:

14. Does the Client have any siblings?

- Yes
- No

15. Siblings

	Name	Age
1		
2		
3		

16. Primary Contact Information

Primary Phone: May we leave a message? Yes No

Alternate Phone: May we leave a message? Yes No

E-mail: May we email you? Yes No

17. OPTIONAL: RELEASE OF INFORMATION I hereby give my authorization for the staff of KidSense Therapy Group to PROVIDE information regarding my child, to the following people/professionals. (Example: Child's Referring Primary Care Physician).

	Name	Phone	Authorization given starting from this Date:
1			

18. OPTIONAL: GATHERING OF INFORMATION I hereby give my authorization for the staff of KidSense Therapy Group to GATHER information regarding my child, from the following people/professionals. (Example: Lactation Consultant or Child' Orthodontist)

	Name	Phone	Authorization given starting from this Date:
1			

19. Please select the modality most closely related to your child's case history. You may be prompted to complete supplemental questions related to your selection here.

☐ Occupational Therapy ☐ Speech Language Therapy ☐ Physical Therapy

20. Marketing Opt in:

Yes, please send me email message notifications of upcoming events, promotions, and news from KidSense Therapy Group.

○ Yes, opt me in! ○ No thank you

Electronic Documentation: I consent to receive unencrypted electronic documentation

○ Yes, I agree ○ No, I do not agree

Release of Photo/Video Agreement: I hereby give my permission for my child to have pictures/videos taken when participating in therapies at KidSense Therapy Group. These pictures/videos may be used for the following purposes (please check the boxes for those that you give permission for):

☐ Future staff training materials to be kept in-house ☐ Brochures and other print promotional materials
☐ Website (internet) promotions and social media posting ☐ Slideshows to be shown at fairs

21. Briefly describe primary reason for seeking therapy:

_____

_____

_____

_____

22. Are there any other languages spoken at home other than English?

○ Yes
○ No

23. If yes:

Which language(s):

_____

What language(s) does the child use/speak?

What language(s) does the child understand?

If applicable, please describe any learning difficulties in the child's native language (please specify language):

24. What percentage of the child's day would you estimate they are exposed/using each language?

Language 1: Language 2:

25. How would you rate your child's proficiency in each language?

Language 1:
○ Limited ○ basic ○ intermediate ○ advanced ○ native like

Language 2:
○ Limited ○ basic ○ intermediate ○ advanced ○ native like

EARLY HEALTH/DEVELOPMENTAL HISTORY

Prenatal and Birth History

26. Length of Pregnancy: Length of Labor:

27. Were there any complications during pregnancy? (i.e. high blood pressure, gestational diabetes, exposure to drugs/alcohol)

○ Yes
○ No

If yes, please explain:

28. General Condition of Mother during Labor:

Type of Delivery: Birth Weight:

29. Please describe the general condition of your child during/after delivery (any special interventions etc.):

30. Please add any other information related to the pregnancy/labor/birth than may be pertinent to your child's therapy.

Developmental History

31. Provide the approximate time (in months/years) at which your child began to perform the following activities or write N/A if not yet attained.

Rolling over:	Sitting Unsupported:	Feed self w/utensils:	Cup drink:
Sleep through the night:	Running:	Hand Dominance:	Tie Shoes:
Name Simple Objects:	Crawling:	Drink w/straw:	Skipping:
Using Words (single):	Use Simple Questions:	Walking Alone:	Finger Feed:
Toilet Trained: Daytime	Toilet Trained: Nighttime	Riding tricycle/bicycle:	Combine 2 words:
Speak in Sentences:	Engage in Conversation:		

32. Does your child have any feeding difficulties (sucking, swallowing, drooling, chewing) currently?

☐ Currently ☐ In the past

If so, please describe:

33. How does your child usually communicate?

☐ gestures ☐ simple words ☐ short phrases
☐ sentences

34. Does your child use speech meaningfully?

- ○ Yes
- ○ No

35. Can you (parent/guardian) understand your child's speech?

- ○ Yes
- ○ No

36. Can playmates, teachers, and relatives understand your child's speech?

- ○ Yes
- ○ No

37. Is your child aware of any difficulties they may be experiencing?

- ○ Yes
- ○ No

38. Does your child currently

- ☐ use a pacifier
- ☐ suck their thumb

39. Has your child used

- ☐ use a pacifier
- ☐ suck their thumb in the past

If so, for how long?

_____

40. Is there any history of speech, language, or hearing problems in your family?

- ○ Yes
- ○ No

If yes, please describe:

_____

41. Describe your child's response to sound:

_____

_____

_____

_____

42. Can your child

- ☐ color
- ☐ write
- ☐ draw
- ☐ paint

43. Does your child seem

- ☐ weak
- ☐ get tired easily

44. Does your child

- ☐ enjoy movement (playground, cars, bikes)
- ☐ prefer sitting activities

45. Does your child

- ☐ lose their balance
- ☐ crash a lot
- ☐ fall down on purpose

46. Does your child

- ☐ avoid certain clothing textures
- ☐ bothered by tags/seams in socks

47. Does your child exhibit any difficulties with self-care such as

- ☐ dressing
- ☐ self-feeding
- ☐ grooming
- ☐ bath time

48. Does your child exhibit any difficulties regarding gross or fine motor skills, including:

- ☐ walking
- ☐ running
- ☐ playing on playground
- ☐ coloring
- ☐ manipulating toys
- ☐ fasteners (zippers, buttons, tying shoes)
- ☐ participating in other activities which require small or large muscle coordination

49. How does your child walk, crawl, sit and move from floor to standing?

_____

_____

_____

_____

50. Does your child appear to have

- ☐ tight muscles
- ☐ loose muscles
- ☐ seem very flexible

51. Receptive Language Development (Understanding Language): Check all that apply

- ☐ Processes information within an appropriate amount of time
- ☐ Understands new concepts easily, incorporates new vocabulary into communication
- ☐ Learns new concepts with repetition, needs cues to use new vocabulary. Visual and physical cues helpful
- ☐ Delay in response time
- ☐ Understands communication when paired with visual and physical prompts
- ☐ Very concrete comprehension
- ☐ Child has difficulty understanding the concepts and language introduced- requires visual and/or physical prompts to understand message

52. Expressive Language Development (Use of Language): Check one

- ☐ Advanced vocabulary, sentence structure and communication skills
- ☐ Age expected vocabulary, sentence structure and communication skills
- ☐ Slightly delayed vocabulary, sentence structure and communication skills
- ☐ Significantly delayed vocabulary, sentence structure and communication skills

Medical History

53. Does your physician have any concerns about your child's nutritional status?

- ○ Yes
- ○ No

If so, please explain:

_____

54. Does your child have a diagnostic label (i.e. birth defect, genetic disorder, developmental delay):

- ○ Yes
- ○ No

If so, list here:

_____

55. Has your child's hearing been tested?

- ○ Yes
- ○ No

If so, what are the results?

_____

56. Does your child have a history of middle ear infections?

- Yes
- No

If so, include when and how often. Has he/she required ear surgery?

_____

57. Has your child had any other surgeries/accidents/hospitalizations?

- Yes
- No

If so, please describe reason/age of onset?

_____

58. Does your child exhibit any of the following illnesses or conditions? Check all that apply and explain below.

	Yes	Explain
Asthma		
Seizures		
Vision Problems		
Lead Poisoning		
Head Injuries		
Frequent Colds		
Kidney Issues		
Upper Respiratory Disorder		
Urinary Issues		
Heart Condition		
Constipation		
Frequent Strep Throat		
Failure to Thrive		
Tension in the jaw		
Reflux		
Diarrhea		
Gastrointestinal Issues		
Teeth grinding		
Snoring		
Mouth breathing		

59. Is your child currently taking any psychiatric or prescription medications?

- ○ Yes
- ○ No

60. If so, please list.

	Medication	Dosage	Frequency	Reason for taking
1				
2				
3				

61. Has your child ever been evaluated by any specialists?

- ○ Yes
- ○ No

If so, please explain:

_____

62. Has your child received any therapy (including Birth-Three, speech/language, occupational, physical, ABA, etc.) in the past?

- ○ Yes
- ○ No

If so what type, when and where? Please give a brief summary of results.

_____

Social/Emotional/Behavioral History

63. Describe the child's personality (check all that apply):

- ☐ Happy
- ☐ Timid
- ☐ Well-liked
- ☐ Moody
- ☐ Talkative
- ☐ Affectionate
- ☐ Bossy
- ☐ Independent
- ☐ Sad
- ☐ Sensitive to criticism
- ☐ Friendly
- ☐ Silly
- ☐ Fearful
- ☐ Withdrawn
- ☐ Easy going
- ☐ Overly dependent
- ☐ Outgoing
- ☐ Confident
- ☐ Funny
- ☐ Quiet
- ☐ Nervous
- ☐ Angry
- ☐ Irritable

64. List or describe your child's strengths and positive characteristics:

65. Please list all organized peer group activities (i.e. hobbies, sports) in which your child participates (include frequency):

66. Please list your child's special interests and/or talents:

67. How does your child respond to changes in routine?

68. How does your child handle new people/new environments/uncomfortable situations?

69. How does your child handle unstructured time (i.e. playground, recess)?

70. Does your child seem flexible or do they struggle with changes/have difficulty with transitions?

71. Does your child engage in any self-soothing behaviors that are of concern or not developmentally appropriate, including:

- ☐ rocking
- ☐ flapping
- ☐ thumb sucking
- ☐ objects that they cannot put down or leave the house without?

If so, please explain:

_____

72. Have there been any major changes in the home recently (separation of parents, moving, family members passing away)?

- ○ Yes
- ○ No

If so, please explain:

_____

73. How does your child interact with peers?

_____

74. How does your child interact with adults?

_____

75. How well does your child make social plans (include how often and how he/she interacts with peers)?

_____

76. Describe your child's attitude towards school/household tasks.

_____

_____

_____

_____

77. Will your child seek help from a peer, teacher, and/or relative?

- ○ Yes
- ○ No

78. How does your child respond to adult reminders/redirection to complete tasks?

_____

_____

_____

_____

79. Briefly describe any difficulties in raising your child and, if applicable, how has this impacted you or your family?

80. Behaviors (check all that apply):

- ☐ Frequent crying
- ☐ Aloof/intemally distracted
- ☐ Oppositional
- ☐ Overactivity
- ☐ Rigid
- ☐ Destructiveness
- ☐ Excessive blinking
- ☐ Hair pulling
- ☐ Lying
- ☐ Legal issues/involvement
- ☐ Motivated
- ☐ Externally distracted
- ☐ Difficulty separating
- ☐ Physically aggressive
- ☐ Withdrawn
- ☐ Tics
- ☐ Rocking
- ☐ Daydreaming
- ☐ Stealing
- ☐ Gang involvement
- ☐ Anxious
- ☐ Impulsive
- ☐ Withdrawal from others
- ☐ Verbally aggressive
- ☐ Temper tantrums
- ☐ Nail biting
- ☐ Thumb sucking
- ☐ Bedwetting
- ☐ Alcohol/drug use
- ☐ Sexual activity

81. Do you have any community organizations involved with your family (i.e. DCF, Probation):

- ○ Yes
- ○ No

If so, please explain:

Educational History

82. Does your child currently attend school?

- ○ Yes
- ○ No

83. Where does your child currently attend school?

Teacher: Grade:

84. Does your child attend any before/after school program(s)/activities?

- ○ Yes
- ○ No

If yes, please describe:

85. Does your child exhibit any academic difficulties?

- Yes
- No

If so, please explain.

_____

86. Does your child attend school regularly?

- Yes
- No

If no, please explain.

_____

87. Are there any attendance concerns

- currently or
- historically?

If so, please describe when and the reason.

_____

88. Has your child had any interdisciplinary incidents?

- Yes
- No

If so, please describe when and the reason.

_____

89. Has your child ever been retained?

- Yes
- No

If so, what grade and school?

_____

90. Has your child received any extra support in/outside of school?

- Yes
- No

If so, please explain:

_____

91. Does your child receive any Tier II and/or Tier III Interventions for academic/behavioral support?

- ○ Yes
- ○ No

If so, please explain:

_____

92. Has your child ever been tested for special education services before?

- ○ Yes
- ○ No

If so, when and what was the outcome?

_____

93. Does your child have an Individualized Educational Plan (IEP) or 504 Plan for school?

- ○ Yes
- ○ No

If so, please briefly explain what it addresses.

_____

94. What does your child enjoy most about school? Favorite subject?

_____

_____

_____

_____

95. Does your child have friends at school?

- ○ Yes
- ○ No

96. Any additional information pertinent to your child's school history?

- ○ Yes
- ○ No

Please explain:

_____

Concerns

Please check all areas that are a concern.

97. Academics:

- ☐ reading
- ☐ writing
- ☐ math skills
- ☐ organization (school materials)

98. Self-Care:

- ☐ Eating/feeding
- ☐ hygiene (bathing, dressing, oral care, hair care)
- ☐ getting ready for school and sleeping

99. Social/Emotional Development:

- ☐ emotional regulation
- ☐ fears
- ☐ coping skills
- ☐ attention
- ☐ making friends
- ☐ problem solving

100. Communication:

- ☐ understanding directions
- ☐ understands vocabulary
- ☐ understands conversation
- ☐ understands nonverbal language (gestures/facial expressions)
- ☐ understands nonverbal language (gestures/facial expressions) comprehending conversations/stories
- ☐ understands academic instruction
- ☐ expressing self clearly and concisely
- ☐ using appropriate vocabulary/grammar
- ☐ using appropriate speech clarity
- ☐ using appropriate voice
- ☐ using appropriate fluency

101. Motor:

- ☐ walking
- ☐ running
- ☐ jumping
- ☐ balance
- ☐ posture
- ☐ endurance
- ☐ writing
- ☐ drawing

102. Sensory:

- ☐ sitting still when expected
- ☐ overly seeking movement
- ☐ able to handle transitions well
- ☐ sensitivities to sounds/clothes/textures and/or visual stimulation

103. How long have you had these concerns?

_____

_____

_____

_____

104. Any significant factors that may have contributed to the concern?

- ○ Yes
- ○ No

If so, please explain:

_____

105. What are your goals/expectations for therapy?

_____

_____

_____

_____