CLIENT CASE HISTORY

Pediatrics

Client Information

Client's Name_____ Today's Date_____
Gender M F Physician_____Date of Birth_____Age____
Diagnosis_____
School/Grade/Teacher **OR** Employer/Position_____
Individual completing form_____
Parent(s) or Guardian(s) name(s)_____
Does the client receive services from any community agencies? _____Yes _____ No If yes, please list agency, supervisor and phone number. _____
_____
_____
Please list any siblings, along with their ages(s)_____

General History

If there was an injury or illness that caused a change in the client's functioning level, please describe it including date of onset and change in skill level. _____
_____
_____
_____
Has the client ever received therapy services in the past? If yes, please describe. _____
_____
_____
Does the client currently utilize any adaptive equipment to assist with completion of daily activities? If yes, please describe. _____
_____
Does the client have equipment needs (wheelchair, braces, etc)?_____
What durable medical equipment provider or orthotist/prosthetist does the client currently use?_____
_____
Does the client have any allergies, including food?_____
Is the client on a special diet or do you consider them to be a selective eater?___Yes ___No If yes, please describe_____
Please list any pertinent medical, personal or social information that you feel may contribute to the evaluation or treatment process. _____
_____
_____
_____
Please list any medications the client is currently taking and why. _____
_____
_____
If difficulties were identified at birth, please indicate complications and outcomes._____
_____
_____

Does the client have a history of:	Yes	No	Please explain any Yes answers (including dates if pertinent) here
Broken bones/fractures			
Sprains/strains			
Surgeries			
Diabetes			
Heart conditions or pacemaker			
High blood pressure			
Cancer			
X-rays, MRI, other tests			
Other			

Has the client had difficulty with:	Yes	No	Please explain any Yes answers (including dates if pertinent) here
Rolling			
Sitting			
Crawling			
Standing			
Walking			
Running			
Lower extremity weakness			
Lower extremity tightness			
One-sided weakness			
One-sided tightness			
Loss of balance			
Decreased coordination			
Safety awareness			
Household chores			
Cooking			
Writing			
Bathing			
Toileting			
Dressing/Grooming			
Feeding self			
Upper extremity weakness			
Upper extremity tightness			
Fine motor coordination			
Focusing on activities			
Dealing with noise, touch and/or movement			
Coping skills			
Problem solving			
Following directions			
Facial weakness			
Facial tightness			
Chewing/swallowing			
Drinking			
Articulation (Speaking)			
Formulating sentences			
Addressing questions			
Memory			
Daily cognitive tasks			
Fluency			
Voicing			
Vocal trauma			
Hearing			
Vision			
Other			