Lisa A. Lenhart, PhD, LLC 100 Park Ave., Suite 105 Rockville, MD 20850

Child Case History Form

Child Information

Date completed:

Name			
Date of Birth		Sex ☐ M ☐ F	
School		Grade:	
Home Address	Street		Apartment
	City	State	Zip Code
Phone Number	Home	Work	Cell
Emergency Contact	Name	Phone	

Parent / Guardian Information

Parent / Guardian One		Sex ☐ M ☐ F	
Phone Number	Home	Work	Cell
Employment	Employer Name	Occupation	
Parent / Guardian Two		Sex ☐ M ☐ F	
Phone Number	Home	Work	Cell
Employment	Employer Name	Occupation	

Who referred you?

Name	
Relationship to Child	
Reason for Referral	

Please List all People in your Home

Name	Relationship	Age

Primary Care Physician		
Name	Address	Phone

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Significant Family Medical History

[e.g., Speech-Language, Hearing, Sensory/Motor or Learning Disability; impaired attention; anxiety / depression; other disease or condition]

Name	Relationship	Diagnosis

Birth and Developmental History

			If concerns, note here
Was mother's health during pregnancy good to excellent?	**Yes**	**No**	
Was baby born at term (due date) or within two weeks before / after the due date?	**Yes**	**No**	
What was child's birth weight?			
Any concerns with labor/delivery?	**Yes**	**No**	
Were there any feeding problems?	**Yes**	**No**	
Were there any sleeping problems?	**Yes**	**No**	
During the first several months of life, was baby's health good?	**Yes**	**No**	

Developmental Milestones			**Additional Information**
When did crawling emerge?	Age:		
When did walking emerge?	Age:		
When did child begin to babble?	Age:		
When did child produce first words?	Age:		
When did child begin combining words?	Age:		
Gross and Fine Motor			
Is there a history of problems with gross motor skills (walking, running, climbing)?	Yes	No	
Are there currently any problems with gross motor skills?	Yes	No	
Is there a history of problems with fine motor skills (e.g., picking up objects, dressing)	Yes	No	
Are there currently any problems with fine motor skills?	Yes	No	
Which hand does child use most often?			

Communication			**Additional Information**
Is your child able to communicate in words?	Yes	No	
Does your child seem to understand what is said?	Yes	No	
Does your child follow spoken directions?	Yes	No	
Is your child understood by others?	Yes	No	

Does child often hesitate when speaking and/ or repeat sounds / words / phrases?	Yes No	
Other Comments:		
Hearing		
Does child have a history of hearing loss?	Yes No	
Does child appear to have difficulty hearing?	Yes No	
Is child consistent in response to sounds and voices?	Yes No	
information regarding child's most recent hearing test.	Date:	Results:

Medical History	**YES**	**NO**	**Additional Information**
Has child ever had a fever of 104° or more?			
Is child currently under treatment for any medical condition?			
Are there any problems with vision?			
Has child had vision screened or tested?			Results:
Does child wear corrective lenses for vision?			
Does child sleep well?			
Does child have a good appetite?			
Is child on a special diet?			

Please complete this section if child takes prescription or over-the-counter medication regularly.	**Prescribing Physician if applicable**	**Dose**
Medication:		
Medication:		
Medication:		
Medication:		
Medication:		

Please provide information regarding history of diseases.	**Age**
Allergies (i.e., food, insect bites, latex, pollen, medication, etc.)	
Chronic Colds	
Ear Infections	
Measles	
Mumps	
Spasms, convulsions, or seizures	
Tonsillitis	
Other:	
Please provide information regarding any injury, surgery, or hospitalization.	**Age**

Previous Evaluations		**Date**	**Sig. Findings?**	**Agency/Person**
Educational / Psychological Testing	Yes No		Yes No	
Occupational Therapy Evaluation	Yes No		Yes No	
Physical Therapy Evaluation	Yes No		Yes No	
Speech Language Evaluation	Yes No		Yes No	

Previous Therapy		**Date**	**Pos. Results?**	**Agency/Person**
Counseling	Yes No		Yes No	
Occupational Therapy	Yes No		Yes No	
Physical Therapy	Yes No		Yes No	
Speech Language Therapy	Yes No		Yes No	
Tutoring	Yes No		Yes No	
Vision Therapy	Yes No		Yes No	

Other Information related to Medical and / or Developmental History
Other information you would like us to know about your child's medical and / or developmental history:

Behavioral Concerns		
Please provide information regarding history of behaviors	**Age**	**Describe Treatment and/or attempts to modify behavior**
Bedwetting		
Depression		
Difficulty separating from parents		
Difficulty sitting still		
Frequent headaches / stomach aches		
History of trauma		
Inability to stay with one activity until completion		
Negative self-esteem		
Nervousness / anxiety		
Noncompliant / defiant		
Physically strikes out at others		
Social skills problem		
Shyness		

Sleeplessness		
Strong fears – nightmares		
Temper tantrums		
Isolated play		
Concerns about play with peers		
Other Information related to Social and Emotional History		
Other information you would like us to know about your child's social and emotional history:		

Educational History

Name of school district where child lives			
Current school			
Previous school(s)			
Highest grade completed	1 2 3 4 5 6 7 8 9 10 11 12		Current Grade:
Has child ever repeated a grade?	**YES**	**NO**	**Please describe, including grade(s) repeated**
Are there any current concerns regarding school performance?	**YES**	**NO**	**Please describe**
Does child receive any special services at school?	**YES**	**NO**	**If so, what services are received?**

Person Completing this Form	
Relationship to the Child	

Signature: _____ **Date:**_____