**Sai Rehab Inc**
*living life without limits*

110 Woodfield Dr, Macon, GA 31210

Tel: (478) 475-7988; Fax: (478) 475-7974

# CASE HISTORY

## (MUST BE COMPLETED BY 2ND APPOINTMENT)

### CONTACT INFORMATION

| | | | |
|---|---|---|---|
| **Child's Name:** | **Sex:** | **Date of Birth:** | **Age:** |
| **Parent(s) Name(s):** | | | |
| **Address:** | | | |
| City: | State: | Zip Code: | |
| **Email:** | | | |
| **Phone #** **Home:** | **Work:** | **Cell:** | |
| **Primary Care Physician:** | **Phone number:** | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Child lives with :** | Birth Parents | Adoptive Parents | Foster Parents | Parent and Step Parent: _____ | One Parent: _____ _____ | Other _____ _____ |

Names and ages of **all people** living in the house:

| | | | | | | |
|---|---|---|---|---|---|---|
| **Child's race/ethnic group:** | Caucasian, Non Hispanic | Native American | Hispanic | Asian or Pacific Islander | African American | Other _____ |

| | |
|---|---|
| **Reason For Seeking Evaluation:** | |
| **School Attending:** | **Grade/Level:** |

# GENERAL INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Mother's general health during pregnancy:** | Poor | | Good | | Excellent | | |
| **Mother on bed rest?** | NO | YES | | | | | |
| | | Explain: | | | | | |
| **Were there any complications, stress during pregnancy?** | NO | YES. Please specify: | | | | | |
| **Were there any complications during labor or delivery?** | NO | YES. Please specify: | | | | | |
| **What is your child's birth order?** | | | | | | | |
| **How long was your pregnancy?** | | | | | | | |
| **Please specify the conditions of your child's birth. (Circle all that apply.)** | Vaginal | Forceps | Vacuum | C-section | Premature | Postmature | Full-term |
| **What was your child's birth weight?** | | | | | | | |
| **What was your child's weight when he / she left the hospital?** | | | | | | | |
| **Did your child require a fetal monitor?** | NO | YES | | | | | |
| **Was your child in the NICU?** | NO | YES | | | | | |
| | | How long? | | | | | |
| **Did your child have any of the following? (circle all that apply)** | Heart defect | | Infection at birth | | Congenital abnormalities | Frequent colds / flu | Seizures |
| | Asthma | | Herpes | | HIV | TB | Any other communicable disease? |
| | Periods of blank staring | | Traumatic brain injury | | Pneumonia | Respiratory problems | Extended high fever |
| **Has your child ever received a hearing evaluation?** | NO | YES / when? | | | | | |
| | | With whom? | | | | | |
| **Has your child ever received a Vision evaluation?** | NO | YES / when? | | | | | |
| | | With whom? | | | | | |
| **Has your child received Occupational Therapy services in the past?** | NO | YES / where? | | | | | |
| | | At what age did your child begin therapy? | | | | | |
| | | How long did/has your child receive(d) therapy? | | | | | |
| | | How frequently was/is your child seen for therapy? | | | | | |
| | | | | | | | |

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|---|---|---|---|---|---|---|
| **Has / Does your Child receive other interventions? (Circle all that apply.)** | NO | YES | | | | |
| | | Speech Therapy | Physical Therapy | Applied Behavior Analysis (ABA) | DIR (Floortime) | Other(s): |
| | | How long? | How long? | How long? | How long? | How long? |
| **If the child has a medical diagnosis, please specify:** | | | | | | |
| **Does your child have a history of ear infections?** | NO | YES | | | | |
| | | How many? | | | | |
| | | At what ages? | | | | |
| **Did your child ever have tubes placed in his / her ears?** | NO | yes | | | | |
| | | At what age? | | | | |
| | | Are the tubes currently in place? | | | | |
| **Does your child currently take any medications?** | NO | YES. Please specify: | | | | |
| **Does your child have any allergies?** | NO | YES. Please specify: | | | | |
| **Has your child experienced any major injuries or hospitalizations?** | NO | YES. Please specify: | | | | |
| **Does your child wear glasses?** | NO | YES | | | | |
| **Does your child have a history of seizures?** | NO | YES. Please specify: | | | | |
| **Is there any family history of speech, language, hearing, attention, or learning issues?** | NO | YES | | | | |
| | | Please specify | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Please note the approximate age when your child achieved the following skills.** | Sitting | Belly crawling | Crawling | Cruising | Walking | First Words | Talking |
| | Hopping | Jumping | Skipping | Running | Riding a tricycle | Riding a 2-wheel bike | Jump rope |

**DRESSING**: Please circle level of independence in completing these tasks
Minimal Assist= Needs help with 1-25% of task
Moderate Assist= Needs help with 26-50% of task
Maximum Assist= Needs help with 51-75% of task

| | | | | | |
|---|---|---|---|---|---|
| **Take off shoes** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Put on shoes** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Take off socks** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Put on socks** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Take off pull-over shirt** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Take off shirt** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Put on shirt** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Manage Snaps** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Manage Buttons** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Manage Zippers** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Manage Belt** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Pull down pants to ankles** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Pull pants up or down** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |
| **Bathe self** | Independent | Minimum Assist | Moderate Assist | Maximum Assist | Dependent |

**TOILET TRAINING**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Is your child currently toilet trained for bladder?** | NO | YES | | | | |
| | | At what age? | | | | |
| **Is your child currently toilet trained for bowel?** | NO | YES | | | | |
| | | At what age? | | | | |
| **Does your child experience urinary/bowel issues?(Circle all that apply.)** | Incontinence during the day | | Bedwetting | Constipation | Loose stools | Lack of awareness |
| | How often? | | How often? | How often? | How often? | How often? |
| **Does your child wear a diaper or pull-up at night?** | NO | YES | | | | |

## SLEEPING

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Does your child have difficulty with sleeping?** | NO | YES | | | | | | |
| | | Falling asleep | Staying asleep | Frequent night waking | | | | |
| | | Do family members have interrupted sleep as a result? | Yes | No | | | | |
| | | How would you rate severity of sleeping issues? | | | | | | |
| **How many times per night does he/she wake?** | Almost never | 1-2 | 3-4 | 5-6 | 7+ | | | |
| **What does your child do when he/she awakens?** | Whimper | Screams | Plays with toys | Goes to parents' bedroom | Puts self back to sleep | Other(s) | | |
| **What activities do you use to get your child back to sleep? (Circle all that apply.)** | Feeding | Singing | Humming | Holding | Rocking | Bouncing | Massage | Other(s) |
| **Describe your routines that are helpful for getting your child back to sleep.** | | | | | | | | |
| **How old was your child when he/she consistently slept through the night?** | | | | | | | | |
| **Does your child seem to require too much or too little sleep or at odd times?** | NO | YES | | | | | | |
| | | How many hours nightly? | | | | | | |
| | | What times of day? | | | | | | |
| **Does your child take naps?** | NO | YES | | | | | | |
| | | Frequency of naps? | | | | | | |
| | | Duration of naps? | | | | | | |
| | | Location of naps? | | | | | | |
| | | Does child need help to fall asleep for naps? | | | | | | |
| **What activities do you use as part of your child's bedtime routine? (Circle all that apply.)** | Bath time Singing/ | Humming | Reading | Hol ding | Bouncing | Massage | Rocking | Other(s) |
| **Please describe any necessary specifics regarding bedtime routine.** | Specify: | | | | | | | |
| **What happens if this routine is disrupted?** | Impact on child: | | | | | | | |

## FEEDING

| | | |
|---|---|---|
| **Was your child breastfed as an infant?** | NO | YES<br>For how long? |
| **If child was bottle fed as an infant, were there any difficulties or concerns?** | NO | YES. Please comment: |
| **Did your child have a strong suck as an infant?** | NO | YES. Please comment: |
| **Did your child frequently spit up as an infant or have reflux?** | NO | YES. Please comment: |
| **Did your child have problems with appetite or weight gain as an infant?** | NO | YES. Please comment: |
| **Did your child have respiratory problems as an infant?** | NO | YES. Please comment: |
| **Does your child refuse to eat, spit out, or gag on foods based on the following characteristics? (Circle all that apply.)** | NO | YES<br>Temperature \| Food texture \| Crunchy foods \| Chewy foods \| Food color \| Mixed food textures<br>Please comment: |
| **Does your child have difficulty with ingesting foods? (Circle all that apply.)** | NO | YES<br>Chewing variety of foods \| Sucking through a straw \| Swallowing variety of foods \| Food falling out of mouth \| Frequent choking \| Managing mixed food textures<br>Please comment: |
| **Is there a disruption in family mealtime as a result of atypical eating patterns?** | NO | YES. Please comment: |
| **Does your child exhibit oral motor sensitivities or seeking? (Circle all that apply.)** | NO | YES<br>Examines objects by placing in mouth \| Gags/vomits frequently \| Bites/chews objects/clothing frequently \| Grinds teeth |
| **Does your child attempt to eat unusual, noxious, or inedible substances or place in mouth?** | NO | YES. Please comment: |
| **Is your child able to sit during meals?** | NO | 1-2 minutes \| 3-5 minutes \| 6-10 minutes \| Entire meal<br>Does this impact the quantity of food ingested? Yes \| No<br>How does this impact harmony at mealtimes?<br>Please comment: |

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| **Where does your child eat meals?** | Specify: | | | | | |
| **What routines do you follow that are helpful for getting your child to eat meals?** | Specify: | | | | | |
| **What happens if this routine is disrupted?** | Impact on child: | | | | | |
| | Impact on family members: | | | | | |
| **LANGUAGE:** | | | | | | |
| **Is English your child's first language?** | Yes | No: What is your child's first language? | | | | |
| **Please note the approximate age when your child achieved the following skills.** | Babbled | Age first word spoken | Age 2-3 word combinations used | Spoke in short sentences | Looking when called | Play peek-a-boo |
| | Respond to name | Imitate sounds | Pointing to simple pictures | Following one-step commands | Following several step commands | Ate solid foods |
| **Has your child's speech development ever been:** | Interrupted | | | Reversed | | |
| | Please comment: | | | Please comment: | | |
| **What concerns do you have regarding your child's speech and language development?** | | | | | | |
| **What have you tried on your own to help your child communicate?** | | | | | | |
| **What is your child's primary or main way of communicating?** | Gestures | Signs | Single words | Phrases | | |
| | Sentences | Augmentative device | Picture exchange | | | |
| **What motivates your child the most?** | | | | | | |
| **How does your child express frustration?** | | | | | | |
| **What sounds do you hear from your child?** | | | | | | |
| **Please provide an estimate of how many words your child has in his / her expressive vocabulary (words spoken)** | | | | | | |
| **How long are your child's sentences?** | | | | | | |
| **Does your child appear to have difficulty understanding you?** | Yes | no | | | | |

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| **How much of your child's speech do you understand?** | 10% or less | 11-24% | 25-50% | 51-74% | 75-100% |

| | | |
|---|---|---|
| **Do you have to have the context in order to understand your child's speech?** | Yes | No |
| **Does your child engage in eye contact during communication?** | Yes | no |

| | | | |
|---|---|---|---|
| **When given a chance, does your child prefer to play:** | Alone | With others | |
| **How does your child interact with others?** | Shy | Aggressive | Friendly |
| | Cooperative | outgoing | |
| **Does your child:** | Answer questions logically? | Greet people arriving or leaving? | Take turns during play or conversation? |
| | Stay on the topic while talking to others? | Retell or tell about everyday events that happened in the past? | Follow one step or two directions? |

| | | |
|---|---|---|
| **Does your child experience any specific challenges in school?** | No | Yes (please explain) |
| **Has the teacher expressed any concerns?** | No | Yes (please explain) |
| **Is your child experiencing teasing or separation from peers?** | Yes | no |
| **Is your child aware of the teasing or separation?** | Yes | No |
| **What skills would you like to see your child achieve from speech and language therapy?** | | |

## AUDITORY

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|---|---|---|---|---|---|
| **Please check all that apply to your child** | Does not seem to enjoy being sung to or read to | Ignores or takes a long time to respond | Startles easily | Has difficulty self-calming | Cries easily with reason not always apparent |
| | Has frequent meltdowns | Sensitive to sounds, which typically don't upset others his / her age | Frequently covers ears to reduce hearing certain sounds | Tries to escape from noisy environments | Likes to make loud noises |

## BEHAVIORAL HISTORY

| | | | | |
|---|---|---|---|---|
| **Please circle how your child was an infant:** | Cried a lot, fussy, irritable | Non-demanding | Alert | Quiet |
| | Passive | Active | Liked being held | Resisted being held |
| | Floppy when held | Tense when held | Good sleep patterns | Irregular sleep patterns |

| | | | | | |
|---|---|---|---|---|---|
| **Please check all that describe your child at present:** | Friendly | Easy-going | Plays well with children his age | Plays well with other children | Has temper tantrums |
| | Difficult to calm when upset /after a tantrum | Destructive with toys | Eats well | Will not eat certain textures | Doesn't like to be touched |
| | Will not touch certain textures | Talkative | Talking interfere with his listening | Clumsy | Restless |
| | Impulsive / Impatient | Difficulty sleeping | Hyperactive | Separation Anxieties | Cooperative |
| | Attentive | Stubborn | Adaptable, flexible | Overly sensitive emotionally | Has nightmares |
| | Cannot easily shift from one activity to another | Sensitive to sounds | Difficulty making a choice | Display extreme mood changes | Defiant |

## SOCIAL FUNCTIONS/FAMILY LIVING

| | | |
|---|---|---|
| **Are you limited in attending family/social gatherings because of your child's behavior/ reaction to events?** | NO | YES. Please comment: |
| **Is your child able to attend parties?** | NO | YES. Please comment: |
| **Are you able to leave your child alone with familiar, but not routine, caregivers for childcare?** | NO | YES. Please comment: |
| **Is your family able to maintain relationships with other families?** | NO | YES. Please comment: |
| **Is your family able to pursue hobbies and interests?** | NO | YES. Please comment: |
| **Does your child have difficulty with different people's voices?** | NO | YES |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Loud voices | Men's voices | Women's voices | Children's voices | Screaming | Crying |

| | |
|---|---|
| **What routines do you follow that are helpful for getting your child to participate in social situations?** | Specify: |
| **What happens if this routine is disrupted?** | Impact on child: |
| | Impact on family members: |

## SOCIAL INTERACTION

| | | | | | |
|---|---|---|---|---|---|
| **Does your child exhibit aggressive behavior?** | NO | YES | | | |
| | | Is it directed towards him/herself? | | NO | YES |
| | | Is it directed towards others? | | NO | YES |
| **What types of behaviors are exhibited?(Circle all that apply.)** | Biting | Pinching | Kicking | Hitting | Other(s) |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Does your child exhibit tantrums?** | NO | YES | | | | |
| | | How frequently do they occur? _____time/day OR _____time/week | | | | |
| | | What triggers the tantrums? | | | | |
| | | On average, how long does a tantrum last? | | | | |
| | | Describe strategies that are effective for helping calm your child during a tantrum. | | | | |
| | | Are tantrums a source of distress to other family members? | NO | YES | | |
| **Is your child easily frustrated, anxious, or overwhelmed?** | NO | YES. Please comment: | | | | |
| **Is your child overly dependent on parent(s) or clingy?** | NO | YES | | | | |
| | | Are separations challenging? | NO | YES | | |
| **Does your child easily escalate from whimper to intense cry?** | NO | YES. Please comment: | | | | |
| **If your child uses atypical repetitive behavior, which behaviors are demonstrated? (Circle all that apply.)** | Hand flapping | Rocking | Head banging | Jumping | Smelling | |
| | Breath holding | Humming | Self-talk | Biting | Mouthing objects | |
| | Visual fixing | Spinning | Teeth grinding | Other(s): | | |
| **Does your child struggle when there is excessive auditory input in his/her environment?** | NO | YES | | | | |
| | | How does your child react? | | | | |
| **Does your child struggle around individuals with certain voice pitches?** | NO | YES. Please comment: | | | | |
| **Does your child struggle to communicate own needs?** | NO | YES. Please comment: | | | | |
| **What is your child's primary form of communication?** | Talking | Singing | Sounds/ Vocalizations | Pointing/ Gesturing | Crying/ Screaming | |
| **How often does your child make eye contact during conversation?** | Less than 25% of the time | 25% of the time | 50% of the time | 75% of the time | 100% of the time | |
| **How often does your child orient to his/her name being called?** | Less than 25% of the time | 25% of the time | 50% of the time | 75% of the time | 100% of the time | |
| **How does your child react in new/unfamiliar situations?** | Specify: | | | | | |
| **Does your child have difficulty paying attention in noisy environments?** | NO | YES | | | | |
| **Does your child regularly avoid** | NO | YES | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **initiation of social interaction?** | | With whom? | | | | |
| | | How often? | | | | |
| **Does your child experience difficulties with language expression? (Circle all that apply.)** | NO | YES | Easily frustrated, anxious, or overwhelmed | Frequently mispronounces words (i.e. bisghetti) | Poor articulation, difficult to understand | Difficulty making choices |
| | | | Flat, monotonous voice | Hesitant speech | Tendency to stutter | Difficulty expressing emotions verbally |

**TACTILE**

| | | | |
|---|---|---|---|
| Circle all that apply | Resists being touched or cuddled | Becomes irritable with weather changes | Becomes excessively irritable with wet diaper or wet clothing |
| | Becomes agitates with hair washing. Intolerance to splashing water | Resists tooth brushing | Avoids certain food textures or temperatures |
| | Refuses all but a few food choices | Refuses to drink from a cup | Desires very spicy foods |
| | Seems unaware of liquid or food left on lips | Avoids contact or becomes upset with messy activities or when in contact with cold, rough, sticky, gooey, dirty, or sandy surfaces | Rarely cries when injured |
| | Still seems to have difficulty refraining from touching things and possibly people | Does not seem to notice when bumped or injured (unless there is blood) | Seems overly sensitive to being touched, esp. light touch |
| | Excessively ticklish | Bothered by clothing (tags, textures, fit of clothing, certain fabrics) | More sensitive to pain than others |

**PROPRIOCEPTION**

| | | | | | | |
|---|---|---|---|---|---|---|
| Circle all that apply | Seems to never get enough movement | Wants excessive amounts of rough and tumble | Seems to tire more easily than other children his/ her age | Slump when sitting | Bang too hard, push too hard, write too hard | Plays too rough, jumps and crashes constantly |
| | Cracks knuckles, chews fingers, bites nails, chews on pens, gums, pencils, clothes, inedible objects | Have difficulty climbing, running, riding a bike | Frequently bump into objects and people accidentally | Appears to be "limp" and "lethargic" all the time | Slumnps at dinner table, desk | |

**PLAY SKILLS/PEER INTERACTION**

| | | |
|---|---|---|
| **Does your child have a strong desire for structure or control?** | NO | YES. Please comment: |