Patient Name: _____ **DOB:** _____

CASE HISTORY FORM ADDENDUM – PEDIATRICS (3 YEARS +)

Please list the names and ages of all individuals living in the home:

Name	Age	Relationship to Patient

What is the primary language spoken in the home? _____

Does the patient attend day care? FULL TIME PART TIME NO

Does the patient attend school? YES NO

If yes, please indicate what school / grade: _____

Is the patient in an adapted classroom? _____

Is your child in after-school care? YES NO

Is there a smoker in the home? YES NO

BIRTH HISTORY *(please circle / check where indicated.)*

Date of birth: _____ ***Born at how many weeks gestation?*** _____

Pregnancy: NORMAL COMPLICATED BY: _____

Delivery:

☐ VAGINAL ☐ SINGLE BIRTH ☐ MULTIPLES: _____

☐ CESAREAN ☐ TWINS ☐ OTHER: _____

List all medical diagnosis your child has been given: _____

_____

Are immunizations up to date: YES ALTERED SCHEDULE NO

Please explain if ALTERED SCHEDULE or NO: _____

Please list all gross motor concerns (walking, jumping, frequent falls…)

_____

_____

Please list all fine motor concerns (handwriting, cutting, dressing…)

_____

_____

Please list all sensory concerns (fear of heights, unable to regulate mood…)

_____

_____

_____

Please list all feeding concerns (gags, refuses, vomits, picky, failure to thrive…)

_____

_____

Please list all speech/language concerns (unable to understand, delayed speech…)

_____

_____

_____

Please check all that describe your child:

- ☐ Friendly, easy going
- ☐ Difficulty sleeping
- ☐ Sleeps well
- ☐ Hyperactive
- ☐ Attentive
- ☐ Cooperative
- ☐ Daydreams often
- ☐ Shy
- ☐ Takes turns well
- ☐ Plays make believe
- ☐ Plays well with others
- ☐ Uses pacifier
- ☐ Sucks thumb
- ☐ Grinds teeth
- ☐ Mouth breather
- ☐ Eats well
- ☐ Startles easy
- ☐ Temper tantrums
- ☐ Overly sensitive to sound
- ☐ Avoids touch
- ☐ Avoids select textures
- ☐ Frustrates easily
- ☐ Difficulty leaving parent
- ☐ Cries easily
- ☐ Stubborn
- ☐ Poor memory
- ☐ Clumsy / falls a lot
- ☐ Shows affection
- ☐ Other: _____
- ☐ Other: _____