12545 Orange Drive - Suite 502
Davie, Florida 33330

BreakthroughTherapyServices
DEVELOPMENTAL BREAKTHROUGHS FOR CHILDREN
www.breakthroughtherapyservices.com

Phone: (954) 474 - 8048
Fax: (954) 474 - 8145
info@breakthroughtherapyservices.com

CASE HISTORY FORM

Date: ____________________

Child's Name: ____________________________________
Date of Birth: ____________________Age:________
Address: _____________________________________ City: _____________________
Zip:____________
Home phone: _________________________ Cell: ____________________________
Work Phone: __________________________ Fax: _____________________________
E-Mail address: ____________________________________

Diagnosis: _____________________________________ Age Diagnosed: ___________
Parent's Name, Occupation and Age:
Father: ____
Mother: ____

School: _____________________________________ Grade: _______
Teacher:________________________

Child's Physician: _________________________________
Name of Practice: _________________________________
Address: ____
Physician's Phone: ______________________________
Physician's Fax: ________________________________

Insurance: _____________________ Policy Holder:______________________________
Policy Number: ____________________________ Group Number:__________________

Areas of concern: ____
____

Please list other children in the family:

Name: Age Sex School Grade
____
____
____
____

What do you feel your child is having difficulties with? Please describe as completely as possible.

____
____
____
____
____
____
____

SPEECH, HEARING AND VISION HISTORY

1. Was your child responsive as an infant (Smile or cry appropriately)?
   a. Yes___ No___

2. When did your child first begin to use single words?_________months.
   a. Short phrases? ________months.
   b. Does your child use sentences now? Yes___ No___
   c. Does your child have a speech or language difficulties? Yes___ No___
   d. If yes, please briefly describe:____
      ____
   e. Does your child understand spoken directions at home? Yes___ No___

3. Are your child's needs/wants anticipated before he expresses them? Yes___ No___

4. At what time were you first concerned about your child's speech/hearing difficulties?
   ____
   ____

5. Can your child be understood (please check all that apply) by parents?_____ relatives?____ peers?_________.

6. Does any other member of the family have a speech or hearing problem? Yes___ No___
   a. If yes, please briefly describe:____
      ____
      ____

7. Has your child ever been seen for a speech/hearing evaluation or examined by anyone other than a physician? Yes___ No___. If yes, please state where and when:
   ____
   ____
   ____

8. Has your child ever received speech, hearing, language, or occupational therapy? Yes___ No___ If yes, please state where and when:
____
____
____

9. Has your child been seen by the eye doctor? If so when and what was the result?
____
____

DEVELOPMENTAL HISTORY

(Please circle or describe where appropriate)

A) Birth History:

1. Conditions during pregnancy: (health, shock, medical care, illness, German measles, other:
____
____
____

2. Any history of miscarriage: Yes___ No___

3. Pregnancy:_________(months) Labor________________(hours)

4. Any medication during pregnancy? Yes___ No___ If yes, please list:____
____

5. Any difficulties at time of birth? Yes___ No___ If yes, please explain:____
____

6. Did the delivery necessitate the use of instruments? Yes ___ No___

7. Type of delivery: feet first____ head first_____ breech (hips first)_____ Caesarean_____

8. Were there any Injuries? Yes___ No___ If yes, please explain:____
____

9. Conditions of baby at birth: Blue_____ Breathing_____ Convulsions_______ Other facts:____

B) Child:

1. Age sat alone______ months.

2. Age walked alone______ months.
3. Toilet training began ______ months.
4. Child completely toilet trained________.
5. Does child sleep well at night? Yes___ No___ If no, please explain:____
6. Is child very active? Yes___ No___ Very quiet? Yes___ No___
7. Does child play well with others? Yes___ No___
8. Coordination: Good____ Clumsy_____
9. Feeding difficulty? Yes___ No___
10. Eye problems? Yes___ No___
11. Any serious illness? Yes___ No___ If yes, please explain:____
12. History of high fever? Yes___ No___
13. History of seizures? Yes___ No___
14. Any serious accidents? Yes___ No___
15. Any surgery? Yes___ No___
16. Have tonsils and adenoids been removed? Yes___ No___
17. Does your child have frequent colds, sore throats, or earaches? Yes___ No___
18. Does your child have allergies? Yes___ No___ If yes, please list:____
19. Is your child on medication? If yes, please list:____
20. If yes to any of the above questions please provide further explanation:____
____
____
____
____
____
____
____
____
____