The TALK Team
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Child Case History

General Information

Today's Date:_____

Child's Name:_____ Date of Birth:_____ Gender:_____

Address: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Allergies: _____

Emergency Contact Information

Name: _____

Number: _____

Relationship to client: _____

Does the child live with both parents? Both Parents:☐ Mother:☐ Father☐ Guardian:☐

If divorced, who has custody? Joint:☐ Mother:☐ Father: ☐ Other:☐

Who does child spend most of his/her time with? _____

Mother's Name:_____ Father's Name:_____

Occupation: _____ Occupation:_____

Home: _____ Home:_____

Cell: _____ Cell:_____

E-mail: _____ E-mail:_____

Siblings: Age: Other People in the home:

_____ _____ _____Relation: _____

_____ _____ _____Relation: _____

_____ _____ _____ Relation: _____

Child's Physician: _____ Phone number:_____

Address: _____ City:_____

What language (s) does the child speak?_____

Has your child received any speech therapy, occupational therapy, or physical therapy services? If yes, please describe what was addressed: _____

_____

_____

_____

_____

Please check appropriate box:	**Yes**	**No**	**Unknown**	**Comments**
Is the child adopted?	☐	☐	☐	If yes, at what age did the child join the family?
Normal pregnancy and delivery?	☐	☐	☐	
Weight at birth?	☐	☐	☐	
Vaginal delivery?	☐	☐	☐	
Cesarean delivery?	☐	☐	☐	

Full-term pregnancy?	☐	☐	☐	
Alcohol, drugs, smoking, or any medications during this pregnancy? If so, please list.	☐	☐	☐	
Did your child have jaundice?	☐	☐	☐	
Was oxygen or respiratory assistance required after birth?	☐	☐	☐	
Was your child breast fed?	☐	☐	☐	
Any difficulties with feeding?	☐	☐	☐	
Did your child have normal feeding, weight gain, sleeping cycles, and temperament?	☐	☐	☐	

Prenatal and Birth History

Describe mother's general health during pregnancy (illness, accidents, prescription and non-prescription medications, etc.).

_____

Length of pregnancy:_____

Medical History:

Child's general health is: Good ☐ Fair ☐ Poor ☐

Is your child on any medications?_____

_____

Describe any major illnesses, accidents, surgeries, or hospitalizations the child has had.

_____

_____

Has your child had ear infections?_____How many? _____

Does your child have tubes? _____

Developmental History

Please complete this section to the best of your ability.

Write the approximate age when the child began to do the following.

Crawl_____ Sit_____ Stand_____ Walk_____ Feed Self _____

Dress self_____Use toilet_____ Use single words_____ Combine words_____

Name simple objects_____ Use simple questions_____

Engage in a conversation_____

Does your child have any motor difficulty, such as walking or

running?_____

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your child has had. _____

_____

Educational History:

School or Preschool:_____ Grade:_____

Teacher (s): _____

Describe any special services your child receives._____

_____

If enrolled for special education services, list main goals of the Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP)._____

_____

Orthodontic History:

What phases has your child completed so far? Please include ages as well as the work completed:

_____

_____

_____

What are future orthodontic plans?:

_____

_____

_____

What are the orthodontist's concerns?:

_____

_____

_____

How did you hear about The TALK Team?

Family Member:_____ Internet:_____

Friend:_____ Phone book:_____

Teacher:_____ Workshop:_____

Doctor:_____ Insurance network:_____

The information provided in this document regarding my child is accurate and consistent to the best of my knowledge.

Signature:_____ Date:_____

Relationship to the patient:_____