WASHINGTON HEALTH SYSTEM
Children's Therapy Center

Case History Questionnaire

Child's Name: _____ Date: _____

Name of person completing this form: _____

Birth date: _____ Gestational age: _____

Diagnosis: _____

Is child currently receiving SLT, OT, or PT at this time? (Frequency, duration, location)
_____
_____
_____

Describe in your own words, any concerns you have and why you are seeking services.
_____
_____
_____
_____
_____

Has your child received any treatment for this concern? (Please give details).
_____
_____
_____
_____
_____

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address?
_____
_____
_____
_____
_____

Please complete and return via mail, in-person, or fax to (724) 942-6104 at least 3 days prior to the appointment.

Please list any medications & dosages: Allergies:	Immunizations: Up to date? – Yes No
Please list any surgeries & dates:	Hospitalizations & dates:
Vision: ___ No concerns ___ far-sighted ___ nearsighted ___ corrective lens ___ not tested Concerns:	Hearing: __ No concerns ___ PE tubes __ hearing loss: conductive sensori-neural __ not tested ____ multiple infections Concerns:
Speech/language concerns: Current method of communication:	Gross motor concerns: Walking/mobility concerns:
Fine motor concerns: Handwriting concerns:	Behavioral concerns:
Feeding concerns: Diet (regular, soft, thin liquids, thick liquids)	Reading concerns:
Is there anything else that you would like to share with us about your child?	

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