Dynamic Development
PEDIATRIC SERVICES

A Path to Progress for *EVERY* Child!

Confidential Case History Form

Date:_____

Child's Last Name: _____ First Name: _____ Sex: M or F

Date of Birth: _____Age: _____

Street Address: _____

City/State/Zip: _____

Telephone #'s: Home:_____ Cell: _____

Work Phone #'s: Mother_____ Father_____

E-mail: _____

Child's School: _____ School Telephone #: _____

Referred By: _____

Allergies: _____

_____

(Please list any food, environmental, etc. allergies)

Current Medications: _____

_____

_____

_____

Current Physicians and Therapists:

_____

_____

_____

_____

4400 East West Highway Suite 32 Bethesda, Maryland 20814 tel 301.951.0303 fax 301.951.0504 www.DynDev.com

PARENT'S INFORMATION

	First and Last Names	Age	Education/ Occupation
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Parent's Marital Status: _____

_____

Please describe the presenting problem and when you first became concerned: _____

_____

_____

_____

_____

_____

Please describe any significant events that happened during your pregnancy. If your child is adopted please explain the circumstances of the adoption._____

_____

_____

_____

_____

			Comments
Was your child breastfed?	YES	NO	_____
Is your child toilet trained?	YES	NO	_____

Did your child have any adverse reactions to his/her vaccination? YES NO

If yes, please tell which vaccination, how old was your child, and the reaction.

_____

_____

_____

MOTOR DEVELOPMENT

At what age did your child reach these developmental milestones?

Rolling? _____

Sitting? _____

Crawling? _____

Walking? _____

Babbling? _____

Pointing? _____

Talking? _____

SCHOOL HISTORY

Child's strengths in school: _____

_____

_____

_____

Child's weaknesses in school: _____

_____

_____

_____

_____

What services is your child currently receiving privately and in the school? (Occupational, Physical, Speech, Vision, Nutritional Therapy) _____

_____

_____

_____

_____

SOCIAL DEVELOPMENT

Does your child have any social or separation anxieties? YES NO _____

_____

If yes, what strategies help make transitions easier for your child?_____

_____

_____

_____

_____

Please describe how your child reacts when frustrated or angry, both at home and at school._____

_____

_____

_____

Please list your child's interests. Please tell us what techniques work best to motivate him/her (i.e. food, praise, toys, stickers, etc.)_____

_____

_____

_____

Please indicate what best describes your child's current play skills.

_____ Playing with toys with a sensorimotor basis (i.e. toys that make sounds, have lights)

_____ Has an interest in toys, but does not play appropriately.

_____ Is beginning to display imaginary play (i.e. feeding the baby).

_____ Displays complex imaginary play.

_____ Will play appropriately with another child.

Please answer yes or no to the following questions and comments on any significant areas impacting your child's development.

Comments _____

_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (Operations, infections, tubes) _____

_____

_____

_____

_____

Ear infections? seldom _____ sometimes _____ often_____

moderate _____ severe_____

Has your child had his/her hearing tested? If yes, what were the results? _____

_____

_____

_____

_____

AUDITORY SYSTEM

Does your child…	YES	NO	COMMENTS
Responds negatively to unexpected sounds or loud noises?	____	____	_____
Holds hands over ears to block out certain sounds?	____	____	_____
Miss some sounds or poorly discriminate sounds?	____	____	_____
Seem confused about the direction of sound?	____	____	_____
Makes loud noises or enjoys strange noises?	____	____	_____
Appears to not hear what you say?	____	____	_____
Has trouble functioning in a noisy environment?	____	____	_____

Does your child…	YES	NO	COMMENTS
Does not respond when his/her name is called, but the child's hearing is o.k.?	____	____	_____
Do you have to repeat instructions?	____	____	_____
Have difficulty remembering what is said?	____	____	_____
Does your child enjoy music?	____	____	_____

SPEECH AND LANGUAGE DEVELOPMENT

Describe any speech problems_____

_____

_____

Describe any language problems _____

_____

_____

POSTURAL FUNCTIONS:

Does your child…	YES	NO	COMMENTS
Continually seeks out movement?	____	____	_____
Spins him/herself?	____	____	_____
Appear unaware when body is in space? (i.e. climbs to high places)	____	____	_____
Likes fast moving carnival rides?	____	____	_____
Avoids playground activities?	____	____	_____
Dislike being turned upside down?	____	____	_____
Avoids balance activities?	____	____	_____
Tire Easily?	____	____	_____
Tend to lie down rather then sit up?	____	____	_____

TACTILE FUNCTIONS

Does your child…	YES	NO	COMMENTS
Avoid getting messy (sand, paint, glue)	____	____	_____
Avoid self-care activities (i.e. brushing teeth, hair washing)	____	____	_____
Have difficulty getting his or her haircut?	____	____	_____
Avoid certain textures of clothing?	____	____	_____
Insist on being bare foot?	____	____	_____
Appear hyper or hypo responsive to pain?	____	____	_____
Wrap him/herself in blankets?	____	____	_____
Like to be under pillows or blankets?	____	____	_____
Insist on holding an object in his or her hand?	____	____	_____
Avoid certain textures of foods?	____	____	_____
Is physically rough with others, but does seem aware or the force he or she is using?	____	____	_____

MOTOR PLANNING ABILITIES/BODY AWARENESS

Does your child…	YES	NO	COMMENTS
Alternate feet when ascending or descending stairs?	____	____	_____
Avoids crossing the midline of his or her body?	____	____	_____
Have difficulty catching a ball with both hands?	____	____	_____
Display consistent hand dominance?	____	____	_____
Have difficulty getting on or off equipment?	____	____	_____

Have difficulty sequencing a series of movements (i.e. dance/karate)?	____	____	_____
Have difficulty getting dressed?	____	____	_____

VISUAL PROCESSING

Does your child…	YES	NO	COMMENTS
Appear sensitive to bright light?	____	____	_____
Become overwhelmed in an environment that has too much visual stimuli?	____	____	_____
Have difficulty maintaining eye contact?	____	____	_____
Explore objects using peripheral vision?	____	____	_____
Have an attraction to spinning objects?	____	____	_____
Have an attraction to horizontal or vertical lines?	____	____	_____
Make reversals when copying?	____	____	_____
Seeks out letters or numbers?	____	____	_____
Have difficulty with puzzles?	____	____	_____
Have messy handwriting?	____	____	_____

SELF REGULATION

Does your child…	YES	NO	COMMENTS
Have difficulty with transitions?	____	____	_____
Seem frequently irritable?	____	____	_____
Have difficulty going to bed at night?	____	____	_____
Get up frequently through out the night?	____	____	_____
Have unpredictable emotional outbursts?	____	____	_____
Need a lot of structure for optimal performance?	____	____	_____

Please let us know anything else about your child that you feel would be important for us to know: