BEYOND BOUNDARIES
THERAPY SERVICES
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PINK CASE HISTORY

---NEW PATIENT---

INDIVIDUALIZED NEEDS ASSESSMENT CASE HISTORY FORM

___OT ___Speech ____PT

Date ___________________________________

Client Name ____ Parent/Caregiver Name _______________________________

DOB: ____________________ Age: __________ Grade _____________ Gender: ☐ Male ☐ Female

Person completing form ____ Relation ____

Is there a language other than English spoken in the home? ☐ yes ☐ no What language? ____________________________________
If yes, does the child speak this language? ☐ yes ☐ no Does child understand this language? ☐ yes ☐ no

Who lives in home with client ____

Client/Caregiver/Family status ☐ married ☐ coparent ☐ single ☐ split custody ☐ foster ☐ other _________________________

How did you hear about Beyond Boundaries? ______________________________ Who were you referred by: ____________________

Primary Care Physician/Pediatrician: ______________________________________ Date of Last Doctor Visit: ____________________

Current Medical Diagnoses:____

Reason for Referral: ____

PARENT / CAREGIVER HISTORY OF CONCERNS

What is your primary concern at this time? ____

____

What are your child's strengths? ____

Has your child received previous therapy evaluation and/or treatment? ☐ yes ☐ no **If yes** ☐ OT ☐Speech ☐ PT

If so, when?___________________________Where?________________________________For how long? ________________

Please specify areas that were addressed during previous treatment ____

When did you first notice your child having difficulty? ____

Is the child receiving any other outside services at this time?

☐ counseling ☐ psychology ☐ chiropractor ☐ behaviorist ☐ autism specialist ☐ early intervention

☐ other ____

PREGNANCY AND BIRTH

Child was born at ______ weeks ☐ head down or ☐ breech. Delivery: ☐ vaginal ☐ with forceps/vacuum ☐ c-section

Were there any complications? ____

Was your child placed in the neonatal intensive care unit? ☐ yes ☐ no If yes, how long? ___________________________________

Please describe any other medical problems, exposure or complications at birth or during pregnancy___________________________

____

MEDICAL HISTORY

Allergies? ☐ yes ☐ no If yes, please describe ____

Hospitalizations? ☐ yes ☐ no If yes, please describe ____

Surgeries? ☐ yes ☐ no If yes, please describe ____

History of seizures? ☐ yes ☐ no If yes, please describe ____

Recent vision exam? ☐ yes ☐ no Date______________ Results______________ Dr. ____________________ Glasses: ☐ yes ☐ no

Recent hearing exam? ☐ yes ☐ no Date______________ Results______________

PE Tubes placed in the middle ear? ☐ yes ☐ no If yes, when?_________________ Physician who inserted the tubes _______________

Current medication(s) including supplements and over the counter medications: ____

____

Current physical limitations: ☐ none please list: ____

Are there any precautions or activities child should not participate in? ____

Special equipment used (ie walker, orthotics, sensory tools, speech device): _________________________________

DENTAL /ORAL HISTORY

Has your child been seen by a dentist? ☐ yes ☐ no If yes, how often?________________ Date of last visit________________________

Any difficulties at the dentist?____

Does your child choke or have difficulty swallowing food or liquid? ☐ yes ☐ no If yes, please describe ____________________

Does your child put toys or objects in their mouth? ____

Does your child brush his/her teeth? ☐ yes ☐ no Does he/she allow you to brush his/her teeth? ☐ yes ☐ no

EDUCATIONAL / COMMUNITY INVOLVEMENT

Daycare / after school program:____

School/Educational program currently attending: ______________________________Present grade level: ____________

Special services received in school: ______________________________Does your child have a current IEP? ☐ yes ☐ no

Who are your child's school OT, PT, Speech?____

Does your child receive behavioral intervention at school? ☐ yes ☐ no

Does your child's teacher have concerns with any of the following areas?

☐ Motor Skills ☐ Social Abilities ☐ Self-help skills ☐ Sensory processing/Regulation ☐ Communication ☐ Academics

What activities/hobbies is your child involved with outside of school: ____

Interests: ____

PARENT / CAREGIVER CONCERNS

Is there anything else you would like us to know about your child that has not been addressed in the previous questions?

____

____

____

I would like more information on the following programs:

☐ The Listening Program	☐ Functional Vision	☐ PROMPT
☐ Hippotherapy	☐ Literacy (Reading/Writing)	☐ Oral Facial Myology
☐ Pediatric Incontinence	☐ Astronaut Program	☐ Feeding/Eating
☐ Constraint Induced Movement Therapy	☐ Savvy Sleeper Program	☐ Speech Camp

For office use only:

If at a later date, client is evaluated by another service,	If at a later date, client is evaluated by another service,
New service ☐ OT ☐ Speech ☐ PT	New service ☐ OT ☐ Speech ☐ PT
Date client made updates to form ________________	Date client made updates to form ________________