OFFICE OF KAREN A. FRANCIOSO-HOWE, MS CCC

Case History Form

Background Information:

Child's name_____
Last First Middle
Address _____
Street Number City State Zip
Phone:_____cell _____ Date of Birth_____
Place of Birth: _____ Gender____
parent email_____
Primary Language Spoken at Home_____

Father's Name _____
Occupation _____

Mother's Name _____
Occupation _____

Other children at Home _____ age _____
_____ age_____

_____ age_____

Child's current school _____
Address and Phone Number_____
Teacher's name_____

Is your child placed on an educational plan ? _____
Is this evaluation a second opinion? _____
If so, please state evaluations completed and date for evaluations.

Please note that testing within a six month period can impact test results. Please convey diagnostic information to the examiner for reliability and a clear interpretation of your child.

Birth History:

Pregnancy: No problems _____
Bleeding _____ Flu / Virus_____
Hypertension_____ Serious illnesses____
Mother's age at the time of delivery_____
Length of pregnancy _____
Duration of labor_____
Apgar Score if possible)_____

Any unusual conditions at or immediately following birth?_____

As an infant, did your child have any:
Feeding problems? _____
Seizures? _____(please describe) _____
Was your baby quiet?_____

Has your child been evaluated at a hospital or clinic?_If yes, Please describe when, who referred your child and what is the diagnosis? _____
Name of Pediatrician _____
Address_____
_____
_____

Do you need a referral for this evaluation? _____

Does your child have any medical conditions?

ear infections _____ high fever _____ seizures_____
asthma/allergies _____ vision / hearing_____
thumb sucking_____ use of pacifier_____

Has your child's hearing be checked ? When_____
Any problems? _____

Does your child take any medications?_____Describe_____

Developmental Information:

Please describe your child's temperament as a baby (was he/she colicky, quiet/overly quiet, happy etc.?_____

Did your child reach most developmental milestones within the expected range? Explain_____

When did he/she begin to talk and use single words? _____
When did he/she begin to talk using 2-3 words?_____
Does your child have a history of ear infections? _____
How many_____? When did they start?_____

Does your child have difficulties with:Please check
Understanding and/or following directions? _____
Understanding basic concepts?_____
Speaking clearly?_____
Carrying on a conversation?_____
Attending to task?_____

Playing or getting along with others?_____
Controlling impulses?_____
Does your child suck his / her thumb?
Name of person who referred your child to this facility?_____ Relationship_____

Name of person completing this questionnaire_____

Is there any information that should be known that will assist in the evaluation and therapy process?_____

_____

_____

Thank you for taking the time to complete this questionnaire thoroughly.

I authorize Karen Howe of Karen Francioso-Howe, MS C.C.C.LLC to release medical and developmental information via phone contact or written documentation to:

_____

_____

_____

Parent / Guardian Signature Date

Should this evaluation not be covered due to my plan coverage, I understand that I will be responsible for this evaluation.