Riley Hospital for Children
Indiana University Health

Case History Form

Thank you for completing this questionnaire. Please return it and the following records for your child:

It is important that Riley Child Development at IU Health have these documents before the appointment.

Medical
- Immunization records
- Medical test reports

Mental Health
- Psychological evaluation
- Recent psychiatry and/or therapist notes

Educational
- Current Individualized Education Program (IEP), current 504 Plan or Response to Intervention (RTI) documentation
- Psychoeducational evaluation
- Speech-language, physical therapy and/or occupational therapy evaluation
- Recent report card

Please mail or fax this questionnaire and these records to:

Intake Coordinator
Riley Child Development Center
705 Riley Hospital Drive
Room 5837
Indianapolis, IN 46202
FAX: 317.944.0194

TODAY'S DATE: __________________

PERSON COMPLETING THIS FORM: ____________________ RELATIONSHIP TO CHILD: ____________

Identifying Information

Child's Name: ____
First Middle Last (Preferred Name)

Date of Birth: ___/___/___ Age: ___ Sex: ___ Male ___ Female

County of residence: _________________________ Local school district: __________________________

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How will you be paying for this appointment?

☐ Private insurance (insurance company name) ___________________________________
☐ Medicaid (please list which type) ___________________________________
☐ Tricare
☐ Children's Special Health Care Services (CSHCS)
☐ Self-pay (I will be responsible for the amount)
☐ Other ___________________________________

Who has legal guardianship of this child? ___________________________________

Is this child living with his or her biological mother? ___ Yes ___ No

Is this child living with his or her biological father? ___ Yes ___ No

Is this child adopted? ___ Yes ___ No If yes, list age of adoption: ___

Is this child a foster child? ___ Yes ___ No If yes, how long has this child lived in your home? ______

County of Wardship: ______________________

County of Caseworker: ______________________ Phone: ______________________

An authorization for health care is required for a foster child. Please include a copy with this form.

Has this child previously been a patient at Riley Child Development at IU Health or Riley Hospital for Children at IU Health? ___ Yes ___ No

If yes, please describe, including dates and any diagnosis given:

____
____
____
____

Parents are: ___ Married ___ Unmarried ___ Divorced ___ Separated ___ Widowed

If both parents work, who cares for your child during working hours? ______________________

During the last 12 months, has your family experienced any of the following difficulties?

___ Death of family member
___ Marital problems
___ Trauma exposure
___ Serious illness
___ Mental health
___ Other ______________________
___ Move
___ Alcohol/drug use

Purpose of the Evaluation

1. What are your questions or concerns regarding your child?

2. When did you first become concerned about your child's problem/s?

3. In what ways would you like us to be of help to you?

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Family Data

Household 1:

Address:____
Street City State ZIP Code

Home phone number: ____________________

1. Caregiver's name: ____________________

   ___ Parent ___ Step-Parent ___ Grandparent ___ Foster Parent ___ Legal Guardian

   Date of Birth: ___/___/___ Email address: ____________________

   Cell phone number: ____________________ Work phone number: ____________________

   Highest grade completed: ____________________ Occupation: ____________________

   Place of employment: ____________________ Work hours: ____________________

2. Caregiver's name: ____________________

   ___ Parent ___ Step-Parent ___ Grandparent ___ Foster Parent ___ Legal Guardian

   Date of Birth: ___/___/___ Email address: ____________________

   Cell phone number: ____________________ Work phone number: ____________________

   Highest grade completed: ____________________ Occupation: ____________________

   Place of employment: ____________________ Work hours: ____________________

List all persons presently living in this household and relationship to child:

Name	Sex	Birthdate	Relation to child	Present or highest grade completed

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Family Data

Household 2: (if applicable)

Address:____
Street City State ZIP Code

Home phone number: ______________________

1. Caregiver's name: ______________________

   ___ Parent ___ Step-Parent ___ Grandparent ___ Foster Parent ___ Legal Guardian

   Date of Birth: ___/___/___ Email address: ______________________

   Cell phone number: ______________________ Work phone number: ______________________

   Highest grade completed: ______________________ Occupation: ______________________

   Place of employment: ______________________ Work hours: ______________________

2. Caregiver's name: ______________________

   ___ Parent ___ Step-Parent ___ Grandparent ___ Foster Parent ___ Legal Guardian

   Date of Birth: ___/___/___ Email address: ______________________

   Cell phone number: ______________________ Work phone number: ______________________

   Highest grade completed: ______________________ Occupation: ______________________

   Place of employment: ______________________ Work hours: ______________________

List all persons presently living in this household and relationship to child:

Name	Sex	Birthdate	Relation to child	Present or highest grade completed

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Developmental History

This section is to be completed by the biological mother of the child if possible.

Please indicate who completed this section of the form:

___ Biological mother ___ Biological father ___ Other ______________________

1. Pregnancy

Was this a planned pregnancy? ___ Yes ___ No

This child was pregnancy number: ____

Total number of pregnancies you have had: ____

Number of live births ____

Number of stillbirths ____

Number of miscarriages ____

Number of abortions ____

Number of living children ____

Number of deceased children ____

Have you had problems during any of your pregnancies? ___ Yes ___ No

Did you have any problems with your pregnancy with this child? ___ Yes ___ No
If yes, please describe the problem and the time it occurred during the pregnancy (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc):
____
____
____

Did you receive regular medical care during this pregnancy? ___ Yes ___ No

Did you take any medication during this pregnancy? ___ Yes ___ No
If yes, please list:
____

Did you smoke during this pregnancy? ___ Yes ___ No
If yes, how many cigarettes per day? ___________________

Did you use alcohol or other drugs during this pregnancy? ___ Yes ___ No

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If yes, please describe your use (what and how often): ___________________________________

2. Delivery

Where was this child born? ____

Hospital City

Age of mother at delivery: ____

Was your baby carried a full nine months? ___ Yes ___ No
If no, please indicate length of pregnancy: _________

Were there any difficulties with delivery? ___ Yes ___ No
If yes, please describe the problems (such as caesarean section, slow heart rate, fever, etc):
____
____

How long did labor last? ____

How much did your baby weigh at birth? ______

Did your baby need any special care during the first few days? ___ Yes ___ No
If yes, please describe:
____
____

Did your baby go home with you when you left the hospital? ___ Yes ___ No
If no, how long did your baby stay in the hospital? __________
If no, what was the reason the baby stayed? ____

3. Early Development

Did you have difficulty caring for your child during the first few weeks at home (such as feeding or chocking problems)? ___ Yes ___ No
If yes, please describe:
____
____

Was your child's early development faster or slower than other children? ___ Yes ___ No
If yes, please explain: ____
____

Has your child ever failed to progress, lost any skills or gone backwards in development? ___ Yes ___ No
If yes, please explain: ____
____

Please list age at which your child did the following tasks:

Task	**Age**
First sat alone	____
First crawled	____
First walked without holding onto anything	____
Rode a tricycle using pedals	____
Moved an object from one hand to the other hand	____
Stacked at least three blocks on top of each other	____
Cut paper with scissors	____
Babbled (e.g., momma, dada, baba)	____
Spoke single words (e.g., cup, dog, cat)	____
Combined words (e.g., "go car")	____
Used sentences (e.g., "me want milk")	____
Became toilet trained	____
Stayed dry at night	____

Does your child have any feeding or sleeping difficulties? ___ Yes ___ No
If yes, please explain: ____
____
____

Does your child receive help in?

Feeding ___ Yes ___ No
Toileting ___ Yes ___ No
Dressing ___ Yes ___ No
Bathing ___ Yes ___ No

At what age do you think your child is currently functioning in the following areas?

Check one	Younger than age	Age appropriate	Above age level
Using his/her body and hands			
Understanding what you say			
Making sounds or talking			
Thinking and solving problems			
Playing with toys or other children			

4. Behavior Management

Do you have any concerns about the management of your child's behavior at home? ___ Yes ___ No
If yes, please explain: ____
____

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How do you discipline your child? ____
____

Are your discipline methods effective? ___ Yes ___ No
If no, please explain: ____

How does your child respond to frustration? ___________________________________
____

How does your child get along with peers, siblings or adults? _______________________
____
____

What toys or activities does your child enjoy? _____________________________________
____

Does your child have any unusual worries? ___ Yes ___ No
If yes, please explain: ____
____

Has your child ever been in counseling or therapy? ___ Yes ___ No
If yes, please list reasons for counseling: _____________________________________
____

Where did counseling occur? _______________________ Dates of counseling: ___________

What do you consider your child's strengths? _____________________________________
____
____

Medical History

Does your child take medication? ___ Yes ___ No
If yes, what? ____

Has your child been or is your child now taking a mineral and or vitamin supplement? ___ Yes ___ No
If yes, please list: ________________________________

Do you feel your child is underweight? ___ Yes ___ No

Do you feel your child is overweight? ___ Yes ___ No

Has your child been or is your child on a special diet? ___ Yes ___ No
If yes, please describe: ____

Does your child have any allergies to food or medications? ___ Yes ___ No

If yes, please describe: ____

Has your child ever been hospitalized? ___ Yes ___ No
If yes, please describe, including child's age: ___________________________________

Has your child ever had a seizure or convulsion? ___ Yes ___ No
If yes, please describe, including the child's age and medication taken:
____
____

Has your child ever been an inpatient or outpatient at Riley Hospital for Children? ___ Yes ___ No

Has your child had any ear infections? ___ Yes ___ No
If yes, when was the last one? ________________

Do you feel your child has trouble hearing? ___ Yes ___ No
If yes, please explain: ____
____

Has your child ever had a hearing test? ___ Yes ___ No
If yes, what were the results and the child's age when tested? ____________________
____

Has a hearing aid ever been prescribed for your child? ___ Yes ___ No

If yes, does your child wear it now? ___ Yes ___ No

Do you feel your child has trouble seeing? ___ Yes ___ No
If yes, please explain: ____
____

Do you feel your child has problems with eye muscle control such as lazy eye, crossed eyes, wall eyes, etc.?
___ Yes ___ No
If yes, please explain: ____
____

Has your child ever had a vision test? ___ Yes ___ No
If yes, what were the results and the child's age when tested? ____________________
____

Have glasses ever been prescribed for your child? ___ Yes ___ No
If yes, does your child wear glasses now? ___ Yes ___ No

Does your child receive regular physical examinations? ___ Yes ___ No
If yes, how often? ____

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Has your child ever received a medical diagnosis? ___ Yes ___ No
If yes, please list: ____

Are your child's immunizations up-to-date? ___ Yes ___ No

Does your child receive regular dental examinations? ___ Yes ___ No

Has your child had any problems with his or her teeth? ___ Yes ___ No

Is there fluoride in your home's drinking water? ___ Yes ___ No

Pleas list any other medical questions or concerns you have:
____
____
____
____
____
____
____
____
____
____
____
____

Place a check next to any illness or condition listed below that any family member has had. This includes the child referred to Riley Child Development. When you check an item, please note the family member's relationship to the child.

Condition	Relationship to Child
____ Alcohol Abuse	____________________
____ Anxiety	____________________
____ Asthma	____________________
____ Attention-Deficit/Hyperactivity Disorder (ADHD)	____________________
____ Autism Spectrum Disorder	____________________
____ Cancer	____________________
____ Depression	____________________
____ Developmental Delay	____________________
____ Diabetes	____________________
____ Drug Abuse	____________________
____ Epilepsy	____________________
____ Frequent/Severe Headaches	____________________
____ Head Injury	____________________
____ Hearing Problem	____________________
____ Heart Trouble	____________________
____ High Blood Pressure	____________________

____ Learning or Reading Problem ____________________

Condition	**Relationship to Child**
____ Intellectual Disability	____________________
____ Psychological Problem	____________________
____ Seizures	____________________
____ Schizophrenia	____________________
____ Speech/Language Difficulties	____________________
____ Suicide Attempt	____________________
____ Vision Problem	____________________
____ Other: ______________________________	____________________
____ Other: ________________________________	____________________

Education/Early Intervention History

Did your child receive services through First Steps? ___ Yes ___ No
If yes, what services were provided and for how long? ___________________________
____

Did your child attend preschool? ___ Yes ___ No
If yes, give ages of attendance: ____
Preschool Name: ____
Preschool Address: ____

Age when child entered kindergarten: ______________
Age when child entered first grade: ______________

Has your child repeated a grade? ___ Yes ___ No
If yes, which grade/s were repeated? ____

Have you requested an evaluation through your child's school? ___ Yes ___ No
If yes, when? ____

Did your child receive testing? ___ Yes ___ No
If yes, please include a copy of the results and recommendations with this form.

Child's current grade placement: ____
School Name: ____
School Address: ____
Teacher: ____

Does your child have an Individualized Education Program (IEP)? ___ Yes ___ No
If yes, what is your child's eligibility category? _______________________________

Please check which of the following services he or she is currently receiving:
___ Resource Room
___Special Education Classroom
___Speech/Language Therapy
___Occupational Therapy
___Physical Therapy
___ Counseling
___ Homebound Instruction
___Extended School Year Services (ESY)
___ Behavior Intervention Plan
___ Teacher Consultation
___ One-on-one Aide
___Tutoring
___ 504 Plan
___ Response to Intervention (RTI)
___ Adaptive PE
___ Title 1
___ ESL/ENL
___ Other

What concerns has your child's teacher(s) shared with you?
____
____
____
____
____
____
____
____
____
____
____
____
____