12/11/2006

Sanilac INTERMEDIATE SCHOOL DISTRICT

CASE HISTORY FORM

Child's Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____

FAMILY MEMBERS Name Age

Mother _____
Father _____
Step Parent _____
Foster Parent _____
Other Children _____
_____
_____
_____
_____

Others Living in Home _____
_____
_____

1. How do your other child(ren) feel toward this child? _____
_____

2. Do you have family and friends close by that help and spend time with the children? _____ Who? _____
_____

PREGNANCY

Pregnancy was ___ normal ___ problems. If problems, what kind: (please circle)
viral infection RH incompatibility vaginal bleeding toxemia chronic disease
trauma Other: _____

BIRTH HISTORY

Child's weight: _____ Length of labor: _____
Special considerations: (please circle)
breech transfused premature, (# of weeks): _____ caesarean
jaundiced Rh negative cord around neck baby rotated
other twin (1st born, 2nd born)
_____

1. Were you released from the hospital before your child? _____
2. How long did your child stay? _____
3. What was it like for you while your child was in the hospital? _____
_____
4. List any special cares that were needed (such as oxygen, incubator, tube feedings, surgery): _____
_____
5. Now that your child is out of the hospital, how are you feeling about caring for him/her at home? About being a parent? (You may use back of page) _____
_____
_____
_____
_____
_____

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DEVELOPMENTAL HISTORY

EARLY LIFE

1. Tell me about your baby when he/she was an infant? _____

SLEEP HABITS

1. Did your baby: (circle one) sleep well sleep restlessly hardly sleep never sleep

FEEDING HABITS

1. Tell me about meal times for your baby, was it a pleasant or difficult time? _____
2. Did your baby: (please circle) eat well have difficulty sucking have difficulty swallowing have food allergies other: _____

MEDICAL HISTORY

1. Are there any ongoing health concerns? _____

   Allergies? _____
2. Is your child receiving any medication? _____yes _____no
3. If yes, please list: _____
4. Has your child has: Any major illnesses? _____
   Any major hospitalization? _____
5. Are there any special things you've noticed that seem unusual or that concern you about your child? _____
6. Does your child have a history of ear infections? _____yes _____no If yes, how many? _____

HEARING

1. How does your child respond to sounds? Does you child like or dislike certain sounds or voices, or types of music? _____
2. Do you feel your child has difficulty hearing? _____yes _____no
3. If yes, are there certain situations where he/she responds better to auditory stimuli (sounds)? _____
4. Has your child ever had a formal hearing evaluation? _____yes _____no
   Where _____ When _____
   Results _____

VISION

1. Do you feel your child has any difficulty seeing? _____yes _____ no. Are there any special things you've noticed about your child's response to light or the way he/she uses eyes and vision? _____
2. Has your child ever had a formal vision evaluation? _____yes _____no
   Where _____ When _____
   Results _____

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DEVELOPMENTAL MILESTONES

1. Tell us some of the things your child can do. _____

2. At what age did your child first: roll _____ sit _____ walk _____
   drink from a cup _____ say first word _____ finger feed _____
   use a spoon _____

3. Do you have special concerns or questions about your child's development? _____

CURRENT HABITS

1. My child currently: (please circle)
   sleeps/naps: well inconsistently restlessly
   eats/drinks: at regular intervals at inconsistent intervals
   consistent amounts inconsistent amounts

   Comments: _____

2. What are the ways your child lets you know what he/she wants? _____

3. Do you know when he/she is happy? (please explain)_____

   sad? _____

   scared? _____

   mad? _____

4. Does your child like to be held or rocked? _____
5. What does your child do when he/she falls or is hurt? _____
6. How does your child respond to sitter? stranger? _____
7. How does your child get around? _____
8. Please list any physicians, therapists, social workers, or other professionals working with your child.

Name	Agency	Title

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FAMILY NAME: _____ DATE: _____

All children and families have their own strengths and needs. Please use this form to tell us how we can be most helpful to your family. We know that your needs will change from time to time and that this will just be a beginning to help us plan together. Answer only those questions that you think will help us know how we can be most helpful to you and your family. You may use the back for any additional information that you feel would be helpful.

What pleases you most about your child? _____

_____

_____

_____

What worries you most about your child? _____

_____

_____

_____

What kind of help or information do you need from us? _____

_____

_____

_____

Do you feel there are things going well for your family and child right now? _____

_____

_____

_____

What would you like your child to be able to do in the next several months? _____

_____

_____

_____

What would you like for your family in the next several months? _____

_____

_____

_____

Besides your family, are there other people you would like to include in the assessment and planning meeting for your child and family? _____

_____