



75 West Commercial Street, Suite 205
Portland, Maine 04101
Voice/TTY: 207/874-1065
Fax: 207/874-1068

SCHOOL-AGED CHILD CASE HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____

Completed By: _____

Relationship to Child: _____

Address: _____

Home Phone: _____

Business Phone: _____

Mother's Name: _____

Place of Employment: _____

Father's Name: _____

Place of Employment: _____

FAMILY:

<u>Person's living in Child's Home</u>	<u>Relationship to Child</u>	<u>Sex</u>	<u>Age</u>

Please describe any serious health, learning, speech and language, and/or hearing problems in the family:

Name of school child attends: _____

School District: _____

Teacher's Name: _____

Grade: _____

CHILD'S DOCTOR(S):

<u>Name</u>	<u>Town</u>	<u>Specialty</u>	<u>Date Last Seen</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other agencies involved with this child (please include after school activities):

<u>Name</u>	<u>Town</u>
_____	_____
_____	_____
_____	_____

CHILD'S MEDICAL HISTORY:

Were there any problems during pregnancy with this child? If yes, please describe:

Were there any problems during birth or immediately after? If yes, please describe:

Birth Weight: _____

How long did this child stay in the hospital after birth? _____

List any medically diagnosed illnesses or conditions: _____

List any serious accidents:

Incident

Approximate age of child

Do you notice, or has a doctor reported, any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Overtired/lacking energy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Frequent high fevers |
| <input type="checkbox"/> Mouth breathing | | |

Please list medications presently being taken by this child and reasons for taking them:

Has this child had an evaluation in any of the following areas?

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Vision | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Speech/language | <input type="checkbox"/> Psychological | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Neurological | <input type="checkbox"/> Other _____ |

CHILD'S DEVELOPMENTAL HISTORY:

Has this child ever had problems learning/doing the following:

- | | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Crawling | <input type="checkbox"/> Walking | <input type="checkbox"/> Running |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Toileting | <input type="checkbox"/> Dressing | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Chewing/Swallowing | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Picking up objects | |

If so, please describe: _____

HEARING AND SPEECH/LANGUAGE HISTORY:

How many ear infections has this child had? _____

When did the last ear infection occur? _____

How were the ear infections treated? _____

By whom? _____

Has this child ever had tubes? If so, when? _____

Does this child have them now? _____

Are you concerned about this child's ability to hear? If so, explain: _____

Has this child had a hearing evaluation? If so, when, where, and what were the results? _____

Describe any problems/delays this child may have had learning to:

Use Words: _____

Combine Words: _____

Use Sentences: _____

Describe any speech/language services this child has received or presently receives: _____

Date of initial session: _____ Date of final session: _____

How often? _____ Individual therapy: _____

Group therapy: _____ Where: _____

By whom: _____

Reasons for current services/current goals: _____

If treatment was discontinued, please explain why: _____

Describe your concerns regarding this child's speech/language: _____

Describe your concerns regarding this child's academic performance and overall performance at present (e.g., reading level, most and least difficult subjects at school, behavior): _____

How much of this child's speech do you understand?

_____ less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Approximately how much of this child's speech do those less familiar with this child understand?

_____ less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Does this child become frustrated when trying to speak? If yes, please describe: _____

Have you talked with this child about your concerns regarding his speech/language and what was the result?

Who has told you they are concerned with this child's speech/language and why? _____

CHILD'S SOCIAL HISTORY:

Does this child like school? _____

Describe how well he/she gets along with peers: _____

Describe this child's favorite portion of the school day: _____

Describe any support services (i.e., Chapter 1, special education, occupational therapy, etc.) this child has received or presently receives in the schools? _____

Please list types of books this child enjoys reading or having read to him/her: _____

Please list favorite T.V. shows/videos: _____

Please list favorite activities, games, toys: _____

Other than academic, please list this child's

Strengths _____

Weaknesses _____

Please describe any changes you would like to see in this child's school programming within the next year:
