CHILD & FAMILY INFORMATION

Child: _____ DOB: _____

Respondent: _____ Relationship: _____

FSC: _____ Date Completed: _____

CAREGIVER/PARENT INFORMATION

Name: _____ DOB: _____

Relationship: _____ Employer: _____

Home Address:
_____
_____

Home Phone: _____
Cell Phone: _____
Other Phone: _____

Name: _____ DOB: _____

Relationship: _____ Employer: _____

Home Address:
_____
_____

Home Phone: _____
Cell Phone: _____
Other Phone: _____

DOES YOUR CHILD HAVE A PARENT WHO DOES NOT LIVE IN YOUR HOME? IF YES, PROVIDE THE CONTACT INFORMATION BELOW:

Name: _____ DOB: _____

Relationship: _____ Employer: _____

Home Address:
_____
_____

Home Phone: _____
Cell Phone: _____
Other Phone: _____

LIST THE OTHER PEOPLE WHO LIVE IN YOUR HOME:

NAME	RELATIONSHIP TO CHILD	AGE	GENDER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME LANGUAGES:	PRIMARY	OTHER
WHAT LANGUAGES ARE SPOKEN IN YOUR HOME?	_____	_____
WHAT LANGUAGES DOES YOUR CHILD UNDERSTAND?	_____	_____
WHAT LANGUAGES DOES YOUR CHILD SPEAK/SIGN?	_____	_____

DOES YOUR CHILD STAY WITH SOMEONE ELSE DURING THE DAY, SUCH AS IN CHILD CARE OR WITH A RELATIVE?
YES / NO (CIRCLE ONE)
IF YES, PLEASE IDENTIFY CONTACT PERSON & ADDRESSS/PHONE NUMBER:
_____
_____
IF SO, WHAT LANGUAGE(S) IS YOUR CHILD EXPOSED TO WITH THIS CAREGIVER?
PRIMARY: _____ SECONDARY: _____

FAMILY HISTORY AND INFORMATION

HAS YOUR CHILD OR ANY OTHER FAMILY MEMBERS RECEIVED EARLY INTERVENTION SERVICES, SPEECH THERAPY, PHYSICAL THERAPY, OR OTHER SPECIAL SERVICES? YES / NO (CIRCLE ONE)
IF YES, EXPLAIN:
_____

FAMILY HISTORY
(PLEASE INDICATE WHICH SIDE OF THE FAMILY YOU ARE REFERRING TO)

PLEASE LIST FAMILY HISTORY OF CHRONIC ILLNESSES OR MEDICAL CONDITIONS:

_____

PLEASE LIST FAMILY HISTORY OF VISION OR HEARING DIFFERENCES:

_____

PLEASE LIST FAMILY HISTORY OF LEARNING/DEVELOPMENTAL DIFFERENCES:

_____

PLEASE LIST FAMILY HISTORY OF MENTAL HEALTH DIFFERENCES:

_____

PRENATAL AND BIRTH HISTORY

DID THE MOTHER RECEIVE REGULAR PRENATAL CARE/CHECKUPS? YES / NO (CIRCLE ONE)
WHEN DID PRENATAL CARE BEGIN (PREGNANCY WEEK OR TRIMESTER)? _____
WERE THERE ANY ILLNESSES OR COMPLICAITONS DURING PREGNANCY? YES / NO
IF YES, EXPLAIN:
_____

DID MOTHER USE ALCOHOL OR DRUGS DURING PREGNANCY? YES / NO
IF YES, EXPLAIN:
_____

DID MOTHER USE PRESCRIPTION DRUGS DURING PREGNANCY? YES / NO
IF YES, EXPLAIN:
_____

WHERE WAS THE CHILD BORN? HOME / HOSPITAL (CIRCLE ONE): _____
CITY: _____ STATE: _____

WAS THE CHILD BORN ON TIME / EARLY / LATE? (CIRCLE ONE)
IF EARLY OR LATE, HOW MANY WEEKS? _____

DID THE MOTHER/CHILD HAVE ANY PROBLEMS DURING OR AFTER BIRTH? YES / NO (CIRCLE ONE)
IF YES FOR MOTHER, EXPLAIN:
_____

IF YES FOR THE CHILD, EXPLAIN:
_____

WHAT WERE THE RESULTS OF THE CHILD'S NEWBORN HEARING SCREENING?
PASS / REFER / UNKNOWN (CIRCLE ONE)

WAS THE CHILD ABLE TO GO HOME WITH THE MOTHER FROM THE HOSPITAL?
YES / NO / UNKNOWN (CIRCLE ONE)

IF NO, WHY AND HOW LONG DID THE BABY STAY IN THE HOSPITAL?
_____
_____

CHILD'S HEALTH AND MEDICAL HISTORY

DOES YOUR CHILD HAVE ANY MEDICAL NEEDS/DIAGNOSIS? YES / NO (CIRCLE ONE)
IF YES, EXPLAIN:

_____

_____

DOES YOUR CHILD TAKE ANY MEDICATIONS? YES / NO

IF YES, PLEASE COMPLETE BELOW:

MEDICATION NAME	TREATMENT FOR WHAT CONDITION?	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____

WHO ARE THE MEDICAL/HEALTH CARE PROVIDERS WHO ARE HELPING OR HAVE HELPED YOUR CHILD?

PEDIATRICIAN/FAMILY DOCTOR: _____ PHONE: _____

OTHER DOCTORS/SPECIALISTS (INCLUDING THERAPISTS):

NAME	SPECIALTY	ADDRESS	PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WHEN WAS YOUR CHILD'S LAST VISIT TO A DOCTOR/SPECIALIST? _____

ARE YOUR CHILD'S IMMUNIZATIONS CURRENT? YES / NO (CIRCLE ONE)

HAS YOUR CHILD'S HEARING BEEN TESTED SINCE BIRTH? YES / NO
IF YES, BY WHOM AND WHAT WERE THE RESULTS?

_____

HAS YOUR CHILD'S VISION BEEN TESTED? YES / NO
IF YES, BY WHOM AND WHAT WERE THE RESULTS?

_____

HAS YOUR CHILD BEEN TO A DENTIST? YES / NO
ARE THERE ANY CONCERNS WITH YOUR CHILD'S DENTAL HEALTH? YES / NO
IF YES, EXPLAIN:

_____

DOES YOUR CHILD USE OR NEED SPECIAL EQUIPMENT? YES / NO

IF YES, EXPLAIN:

_____

HAS YOUR CHILD HAD ANY SIGNIFICANT HEALTH PROBLEMS? YES / NO

EXAMPLES OF SIGNIFICANT HEALTH PROBLEMS INCLUDE: SEIZURES, INFECTIOUS DISEASES, CHRONIC ILLNESS, CHRONIC EAR INFECTIONS, BREATHING PROBLEMS, REFLUX, ECZEMA OR SKIN PROBLEMS, ALLERGIES, VISION/HEARING PROBLEMS, ETC.

IF YES, PLEASE EXPLAIN AND PROVIDE DATE AND TREATMENT:

_____

_____

HAS YOUR CHILD HAD ANY HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES? YES / NO

IF YES, EXPLAIN:

_____

CHILD DEVELOPMENT

WHAT IS YOUR CHILD'S PERSONALITY LIKE MOST OFTEN? (HAPPY, SHY, OUTGOING, REALLY QUIET, VERY ACTIVE, ETC.) _____

WHAT ARE YOUR CHILD'S FAVORITE TOYS, GAMES, OR ACTIVITIES?

_____

WHAT DO YOU ENJOY MOST ABOUT YOUR CHILD? (I.E. STRENGTHS, BEST QUALITIES, ECT.)

_____

PLEASE CHECK THE APPROPRIATE COLUMN TO TELL US ABOUT WHEN YOUR CHILD LEARNED THE SKILLS LISTED BELOW. REMEMBER THAT EACH CHILD IS DIFFERENT, SO YOU MAY RESPOND DIFFERENTLY THAN THE "AVERAGE AGE". *IF EARLIER OR LATER, PLEASE WRITE THE APPROXIMATE MONTH OF AGE YOUR CHILD LEARNED THE SKILL*:

SKILLS	AVERAGE AGE (MONTHS)	AVERAGE	EARLIER	LATER	LEARNING	NOT YET
HELD HEAD UP AND STEADY	3-6					
ROLLED OVER	4-7					

CRAWLED	7-10					
SAT WITHOUT HELP	7-10					
SAID: "BABA", "DADA" OR "NANA"	7-10					
SAID FIRST WORDS	10-13					
SAID 2-WORD PHRASES: "MORE MILK" OR "GO CAR"	18-24					
TALKED IN 3-4 WORD SENTENCES	24-30					
BEGAN PRETEND PLAY: FEED DOLL WITH SPOON ETC.	24-30					
TOILET TRAINED	24-36					
PRETEND PLAY WITH OTHER CHILDREN: PLAY HOUSE ETC.	30-36					

DID YOUR CHILD LEARN ANY OF THES SKILLS LISTED ABOVE, AND THEN LOSE THE ABILITY TO DO THAT SKILL?
YES / NO (CIRCLE ONE)
IF YES, EXPLAIN:

_____

CONCERNS OR QUESTIONS

WHAT CONCERNS DO YOU HAVE ABOUT YOUR CHILD'S DEVELOPMENT?

_____
_____
_____

DIFFICULTY WITH COMMUNICATION
SUCH AS LISTENING, UNDERSTANDING WHAT OTHERS SAY, TALKING, ETC.
YES / NO (CIRCLE ONE)
IF YES, EXPLAIN:

_____

DIFFICULTY WITH MOVEMENT
SUCH AS SITTING, STANDING, BODY MOVEMENT, USING HANDS NAD FINGERS, ETC.
YES / NO
IF YES, EXPLAIN:

_____

DIFFICULTY PAYING ATTENTION, LEARNING, OR CHANGING FROM ONE ACTIVITY TO THE NEXT, ETC.
YES / NO
IF YES, EXPLAIN:

_____

DIFFICULTY WITH EATING, DRESSING, OR SLEEPING, ETC.
YES / NO
IF YES, EXPLAIN:
_____

DIFFICULTY WITH SENSITIVITY SUCH AS OVER- OR UNDER-SENSITIVE TO TOUCH, TEXTURES, FOODS, SOUNDS, ETC.
YES / NO
IF YES, EXPLAIN:
_____

DIFFICULTY INTERACTING WITH OTHER CHILDREN, ADULTS, ETC. YES / NO
IF YES, EXPLAIN:
_____

OTHER CONCERNS NOT DESCRIBED ABOVE? YES / NO
IF YES, EXPLAIN:
_____

DID YOU DISCUSS THESE CONCERNS WITH YOUR CHILD'S DOCTOR OR ANOTHER HEALTH PROVIDER? YES / NO
IF YES, EXPLAIN WHAT INFORMATION YOU WERE GIVEN. WHO GAVE IT TO YOU AND WHEN?
_____

IS THERE ANYTHING ELSE YOU WANT US TO KNOW THAT WILL HELP US WORK WITH YOUR CHILD AND FAMILY?
_____

FAMILY SERVICE COORDINATION OBSERVATIONS: _____
_____