

## Case History Form

*Please complete to the best of your ability and return to your child's classroom teacher.*

Date: \_\_\_\_\_ Person completing this form: \_\_\_\_\_

**A. Identification:**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M / F

Mother's/Guardian's Name: \_\_\_\_\_

Phone Number: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Address: \_\_\_\_\_

Father's/Guardian's Name: \_\_\_\_\_

Phone Number: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Address (if different from Mother's address): \_\_\_\_\_

Is your child living with both parents? Yes / No If no, with whom is the child living?

Is your child adopted? Yes / No If yes, is he/she aware? Yes / No

Is there a history of learning difficulties in the family? Yes / No

If yes, please explain: \_\_\_\_\_

Please list all siblings:

Name	Age	Sex	Grade	Speech, Hearing, Learning, Physical and/or Medical Problems

Please list other individuals living in the home: \_\_\_\_\_

**B. Birth History:**

- 1. Describe mother's health during pregnancy: \_\_\_\_\_  
\_\_\_\_\_
- 2. Was mother using drugs / alcohol during the pregnancy? Yes / No
- 3. Was your child's birth normal? Yes / No If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

**C. Medical History:**

- 4. Do you have any medical concerns for your child? Yes / No If so, please explain: \_\_\_\_\_  
\_\_\_\_\_
- 5. Does your child have a medical diagnosis and/or is he/she in the process of obtaining a diagnosis? Yes / No If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
- 6. Has your child had problems with any of the following? (Please circle all that apply.)

Vision	Allergies	Adenoids
High Fever	Ear Infections	Tonsils
Convulsions	Hearing Loss	Sleep Patterns
Blackouts or passing out spells	Tubes in Ears	Gagging / Choking Easily
Other (please describe):		

- 7. Has your child ever been to the hospital? Yes / No If so, when and for what reason(s)?  
\_\_\_\_\_
- 8. Is your child under the care of a doctor? Yes / No If yes, why? \_\_\_\_\_  
\_\_\_\_\_
- 9. Is your child taking medication? Yes / No If yes, what type? \_\_\_\_\_  
Why was he/she prescribed this medication? \_\_\_\_\_  
\_\_\_\_\_
- 10. Has your child's vision been tested? Yes / No If yes, when? \_\_\_\_\_
- 11. Has your child's hearing been tested? Yes / No If yes, when? \_\_\_\_\_
- 12. When was your child's last visit to the dentist? \_\_\_\_\_

**D. Speech and Language History:**

13. Do you have any speech or language concerns for your child? Yes / No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

14. Has your child had any therapy for speech, language or hearing? Yes / No If yes, when?  
\_\_\_\_\_

15. At what age did your child speak his/her first words? \_\_\_\_\_

16. How well can your child's speech be understood by you and/or your family? \_\_\_\_\_  
By relatives and strangers? \_\_\_\_\_

17. What is the main language spoken in the home? \_\_\_\_\_ Are there other languages spoken at home? Yes / No If yes, what are they? \_\_\_\_\_

**E. Motor Skills History**

18. At what age did your child first crawl? \_\_\_\_\_ Walk? \_\_\_\_\_

19. Do you have any physical concerns for your child regarding his/her ability to get in/out of bed, sit, walk, play common games/sports, dress, etc.? Yes / No If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

20. Is your child using any equipment/aids to help them move around or walk? Type of aid:  
\_\_\_\_\_

21. How much time does your child spend doing paper/pencil and/or scissor activities at home?  
\_\_\_\_\_ minutes per day / week

22. Is your child's printing/hand-writing legible to you? Yes / No  
To relatives/strangers? Yes / No

23. Does your child use any adaptive equipment at home? Yes / No If yes, please describe:  
\_\_\_\_\_

24. Have any changes been made to your home to increase your child's independence? Yes / No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**F. Home and Family Information:**

25. Does your child get along with family members? Yes / No
26. Does your child separate from his/her family without crying or fussing? Yes / No
27. Does your child prefer to play alone? Yes / No
28. Who are your child's friends (both at school and away from school)? \_\_\_\_\_  
\_\_\_\_\_
29. Are your child's friends a positive influence in his/her life? Yes / No
30. Does your child need a lot of discipline? Yes / No
31. What types of discipline are most effective for your child? \_\_\_\_\_  
\_\_\_\_\_
32. Are home responsibilities done willingly? Yes / No
33. What types of responsibilities does your child have in the home? \_\_\_\_\_  
\_\_\_\_\_
34. What does your child do in his/her spare time? \_\_\_\_\_
35. Does your child have difficulty paying attention? Yes / No If so, under what conditions?  
\_\_\_\_\_

**G. Education Information:**

36. Do you have any educational concerns for your child? Yes / No If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
37. Has your child ever repeated a grade? Yes / No If yes, which one(s)? \_\_\_\_\_
38. How does your child feel about school? \_\_\_\_\_  
\_\_\_\_\_
39. What is your impression of your child's learning abilities? \_\_\_\_\_  
\_\_\_\_\_
40. What have you found to be the most satisfactory ways of helping your child? \_\_\_\_\_  
\_\_\_\_\_
41. On average, how much time does your child spend on schoolwork per night? \_\_\_\_\_

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42. On average, how much time does your child spend reading per night? \_\_\_\_\_

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43. Has your child had any prolonged absences from school? Yes / No If yes, please state which grade(s) and the reason(s) for the absence: \_\_\_\_\_

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44. Which other schools has your child attended? \_\_\_\_\_

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45. Have you seen any changes in your child's behavior? Yes / No If yes, what kinds of changes have you seen? \_\_\_\_\_  
What might be the cause(s) for this change? \_\_\_\_\_

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46. Describe your child's strengths. \_\_\_\_\_

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Please add any information you feel will help us in understanding your child and his/her strengths and weaknesses:

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