Northwest School Division
Case History Form
School Year 2018 - 2019

General Information

Date: **Person completing this form:** **Relationship:**

Identification

Child's Legal Name:
Address:
Grade:
Child's Usual/Preferred Name:
School Year:
Gender:

Mother/Caregiver:
Work Phone:
Relationship:
Cell Phone:
Home Phone:
Email:

Father/Caregiver:
Work Phone:
Relationship:
Cell Phone:
Home Phone:
Email:

With whom is the child living?:
Is your child adopted?:
Other individuals living in the home

Medical History

Describe mother's health during pregnancy:
Were there issues during pregnancy (ex. Illness, gestational diabetes, premature birth, alcohol use, chemical exposure)?: Yes/No
If yes, Please explain:

Was your child's birth normal?: Yes/No
If No **Please explain:**

Do you have medical concerns for your child?: Yes/No
If yes, **Please explain:**

Does your child have a medical diagnosis?: Yes/No
If yes, **Please explain:**

Is your child in the process of obtaining a medical diagnosis?: Yes/No
If yes, **Please explain:**

Has your child had problems with any of the following?

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Vision: Yes/No

If yes, **Please explain:**

High Fever: Yes/No
If yes, **Please explain:**
Loss of Consciousness: Yes/No
If yes, **Please explain:**

Allergies: Yes/No
If yes, **Please explain:**

Ear Infections: Yes/No
If yes, **Please explain:**

Hearing Loss: Yes/No
If yes, **Please explain:**

Tubes in Ears: Yes/No
If yes, **Please explain:**

Tonsils: Yes/No
If yes, **Please explain:**

Adenoids: Yes/No
If yes, **Please explain:**

Sleep Patterns: Yes/No
If yes, **Please explain:**

Gagging or Choking: Yes/No
If yes, **Please explain:**

Other:
Please explain:

Has your child ever been to the hospital?:
Please specify the reason:

Is your child under the care of a doctor?:
Please specify the reason:
Please specify where and by whom:
Is there a specific concern being addressed?:

Is your child taking medication?: Yes/No

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Please specify the medication:
Please specify the reason:

Has your child's hearing been tested?:
Please specify when:
Please specify where and by whom:
Please specify the findings and recommendations:
Does your child need an amplification device or hearing aid?

Has your child's vision been tested?:
Please specify when:
Please specify where and by whom:
Please specify the findings and recommendations:
Does your child need contacts/glasses?

Has your child been to a dentist?:
Please specify when:

Home and Family Information

Does your child usually get along with family members?

Does your child separate from his/her family without crying or fussing?

Does your child prefer to play alone?

Who are your child's friends (both at school and away from school)?

Are your child's friends a positive influence in his/her life?

Does your child participate in out-of-school activities?

What types of discipline are most effective for your child?

Does your child have responsibilities in the home?

What does your child do in his/her spare time?

Does your child have difficulty staying on task at home?

Speech and Language History

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Do you have concerns about your child's speech? Yes/No
If yes, **Please explain:**

Do you have concerns about your child's language development?

If yes, **Please explain:**

Has your child had therapy for speech, language or hearing?

If yes, Please specify when:
Please specify where and by whom:
Please specify the reason for referral:
Is there an SLP report available?: No

At what age did your child speak his/her first words?:

How well can your child's speech be understood?:
By you and/or your family:
By relatives and strangers:

Motor Skills History

At what age did your child first crawl?:

At what age did your child first walk?:

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
Please explain:

Does your child use equipment/aids to help them move around or walk?: Yes
Please explain:

Does your child participate in paper/pencil and/or scissor activities at home?:

Is your child's printing/hand-writing legible to you?:

Does your child use adaptive tools during household activities (adapted cutlery, fasteners, velcro, oversized paper?: Yes
Please explain:

Have physical changes been made to the layout, accessibility, or usability of your home to increase your child's independence (eg, ramp, lift, stool, etc)?: Yes
Please explain:

Education Information

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Does your child have difficulty paying attention at school?:
Under what circumstances:

Do you have any educational concerns for your child?:
Please explain:

Has your child ever repeated a grade?:
Which ones:

How does your child feel about school?:

What is your impression of your child's learning abilities?:

What have you found to be the most useful ways of helping your child with learning?:

Does your child work on schoolwork at home?:
How much time in an average day?:

Does your child read at home?:
How much time in an average day?:

Has your child had any prolonged absences (2 wks+?) from school?:
Please list additional schools your child has attended:

Have you seen any recent changes in your child's behavior?:

What might be causing this change?:

Describe your child's strengths:

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