Case History Form

School Year 20__ - 20___

Northwest School Division #203

Date: _____ Person Completing form: _____

Relationship to Student: _____

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

A. IDENTIFICATION

Child's name: _____ DOB: d___ m___ y____ Gender: __

School: _____ Teacher: _____ Grade: _____

Guardian 1: _____ _____ Relationship to Child: _____

First Name *Last Name*

Mailing Address: _____

House/Box Number *Street* *City/Town* *Postal Code*

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Guardian 2: _____ _____ Relationship to Child: _____

First Name *Last Name*

Mailing Address (if different from Guardian 1): _____

House/Box Number *Street* *City/Town* *Postal Code*

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email (if different from Guardian 1): _____

With whom is the child living?_____

Is your child adopted? ☐ Yes ☐ No If yes, are they aware? ☐ Yes ☐ No

Please list all siblings:

Name	Age	Gender	Grade	Speech, Hearing, Learning, Physical and/or medical issues

Please list other individuals living in the home: _____

_____

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B. BIRTH HISTORY

1. Describe mother's health during pregnancy:_____

_____

2. Were there issues during pregnancy? (ex. illness, gestational diabetes, premature birth, drug/alcohol use, chemical exposure, etc): ☐ Yes ☐ No If yes, please explain: _____

_____

3. Was your child's birth 'normal'? ☐ Yes ☐ No If no, please explain: _____

_____

C. MEDICAL HISTORY

1. Do you have any medical concerns for your child? ☐ Yes ☐ No If yes, please explain: ___

_____

2. Does your child have a medical diagnosis? ☐ Yes ☐ No If yes, please explain: _____

_____

3. Is your child in the process of obtaining a medical diagnosis? ☐ Yes ☐ No If yes, please explain:

_____

4. 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 Tubes in Ears

Headaches Blackouts or passing out spells Gagging/Choking Easily

Other, (Please describe):_____

5. Has your child ever been to the hospital? ☐ Yes ☐ No If so, when and for what reason(s)?

_____

6. Is your child under the care of a doctor? ☐ Yes ☐ No If yes, why, and who is the doctor?

_____

7. Is your child taking medication? ☐ Yes ☐ No If yes, what type?: _____

Why were they prescribed this medication? _____

8. Has your child's vision been tested? ☐ Yes ☐ No If yes, when and what were the results?

_____

9. Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and what were the results?

_____

10. When was your child's last visit to the dentist? _____

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D. HOME AND FAMILY INFORMATION

1. Does your child usually get along with family members?_____
2. Does your child separate from their family without crying or fussing? _____
3. Does your child prefer to play alone?_____
4. Who are your child's friends (both at school and away from school)?_____
5. Are your child's friends a positive incluence in their life?_____
6. Does your child participate in out-of-school activities?_____
7. What types of discipline are most effective for your child?_____
8. Does your child have responsibilities in the home? _____
9. What does your child do in their spare time? _____
10. Does your child have difficulty staying on task at home?_____

E. SPEECH AND LANGUAGE HISTORY

1. Do you have any speech and language concerns for your child? ☐ Yes ☐ No If yes, please explain:

_____

2. Has your child had any therapy for speech, language or hearing? ☐ Yes ☐ No If yes, when?_____

_____

Where did they receive services? _____

3. At what age did your child speak their first words?_____
4. How well can your child's speech be understood by you and/or family? _____

By relatives and strangers? _____

5. What is the main language spoken in the home?_____

Are there other languages spoken in the home? ☐ Yes ☐ No

If yes, what are they?_____

F. MOTOR SKILLS HISTORY

1. At what age did your child first crawl? _____ 2. At what age did your child first walk? _____
3. Do you have any physical concerns for your child regarding their ability to get in/out of bed, sit, walk, play common games/sports, dress, etc? ☐ Yes ☐ No If yes, please explain: _____

_____

4. Does your child use equipment/aids to help them move around or walk? ☐ Yes ☐ No

If yes, please explain:_____

5. Does your child participate in paper/pencil and/or scissor activities at home? ☐ Yes ☐ No
6. Is your child's printing/handwriting legible to you?_____
7. Does your child use adaptive tools during household activities (adapted cutlery, fasteners, velcro, over-sized paper)? ☐ Yes ☐ No If yes, please exlplain: _____
8. Have physical changes been made to the layout, accessibility, or usability of your home to increase your child's independence (ex: ramp, lift, stool, etc.)? ☐ Yes ☐ No If yes, please explain:_____

_____

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G. EDUCATION HISTORY

1. Do you have any educational concerns for your child? ☐ Yes ☐ No If yes, please explain:_____

_____

2. Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which one(s)?_____

3. How does your child feel about school?_____

_____

4. What is your impression of your child's learning abilities?_____

_____

5. What have you found to be the most satisfactory ways of helping your child?_____

_____

6. On average, how much time does your child spend on schoolwork per night? _____

7. On average, how much time does your child spend reading per night? _____

8. 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:_____

_____

9. Which other schools has your child attended? _____

10. Have you seen any changes in your child's behaviour? ☐ Yes ☐ No If yes, what kinds of changes have you seen? _____

What might be the cause(s) for this change? _____

_____

11. Describe your child's strengths _____

_____

_____

_____

_____

_____

_____

Please add any information you feel will help us in understanding your child and their strengths and weaknesses:_____

_____

_____

_____

_____

_____

_____

_____

_____

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