INTAKE CASE HISTORY FORM

I. Identifying Information Today's Date: _____

Student's Name: _____
Last First Middle
Date of Birth: _____/____/_____ Gender: Male / Female

Has there been a change in address, since the student's application for admission to MSD?
Yes / No If yes, please include new address _____
_____

Student's Social Security Number: _____/_____/_____
Since what date has the student lived in MD? _____

II. Developmental History

A. Pre/Post Birth:

Prenatal complications - please identify any factors that may have affected the child during pregnancy (i.e., bleeding; medications; injury; sickness; in-utero substance exposure; etc.):
_____
_____

Length of pregnancy: Full term/Premature How many weeks? _____
Birth weight: _____ Birth height: _____ Health of child at birth: _____
Hospital where child was born: _____
Postnatal complications (jaundice; breathing problems; NICU stay; extended hospital stay; artificial ventilator), if any: _____
_____

B. Developmental Milestones (when did your child. . . . ?):

Crawl _____ Stand alone _____ Walk alone_____ Begin babbling/talking_____
Begin using sign language_____ Accomplish toilet-training_____

Any parental concerns regarding your child's development?_____
_____
_____
_____
_____
_____
_____

III. Medical History

Name and address of pediatrician: _____
_____

Is your child currently taking any prescription medications? Yes / No
If yes, please list:

Has your child ever had surgeries or been hospitalized? Yes / No
If yes, please list all along with the doctor's name that treated the condition:

Does your child have any restrictions to physical activities, sports, or swimming? Yes / No
If yes, please explain:

Does your child wear eyeglasses and/or contact lenses? Yes / No

Date of child's last vision exam? _____
Date of child's last dental exam? _____

Is there a family history of medical or emotional/behavioral concerns? Yes / No
If yes, please explain:

<u>Motor Coordination</u>:
Handedness: Right / Left
Can your child: Button - Yes / No Snap - Yes / No Zip - Yes / No
Dress independently - Yes / No Tie own shoes - Yes / No
Eat independently - Yes / No Participate in Sports - Yes / No
Please describe any restrictions or limitations:
_____
_____

<u>Nutrition</u>:
Does your child have a medical condition that requires a special diet? Yes / No
If yes, please explain: _____
_____
List any food allergies/ food intolerance or ethnic/religious food restrictions: _____
_____
Has your child ever been evaluated for feeding/swallowing? Yes / No
If yes, please explain:
_____
_____

Does your child currently receive any of the following services?

Service	Yes	No	Where / Who?	How Often?
Speech-Language therapy				
Aural (re)habilitation/ Auditory Training				
PT (Physical Therapy)				
OT (Occupational Therapy)				
Educational Tutoring				
Counseling Services				
Behavior Support (FBA, BIP)				
Other				

Please indicate if your child has experienced any of these conditions:

Illness or Medical Concern	Yes / No	Age of Onset / Diagnosis	Explain (Use back of paper, if necessary)
Attention deficit disorder (ADHD)			
Allergies			
Anemia			
Anxiety			
Asthma			
Chicken pox			
Colic (as a baby)			
Concussion			
Depression			
Diabetes			
Ear infections			
Encephalitis			
Fainting or Dizziness			
Head injury			
Heart problems			
High fevers			
Measles			
Mumps			
Menses			
Meningitis			
Migraines / headaches			
Pneumonia			
Seizures			
Serious injuries			
Skin Conditions			
Strep Infection			
Ushers Syndrome / Retinitis Pigmentosa			
Whooping Cough			
Other:			
Other:			

IV. Hearing Status

Child's age when hearing loss was first suspected: _____
Child's age when hearing loss was confirmed by professional? _____
Name of center/agency where test was completed: _____

Cause of child's hearing loss: _____
Is there a history of hearing levels changing? Yes / No
If yes, please explain: _____

Is anyone in the family or extended family Deaf or Hard of Hearing? Yes / No (If yes, please list)
_____

Describe child's hearing levels: Right ear _____ Left ear _____
Date of most recent audiological exam: _____ Audiologist: _____
Name of center/agency where test was completed: _____

Does your child own a hearing aid? Yes / No (If Yes, please fill out questions below)

If yes, Right Ear (Make/Model) _____ Left Ear (Make/Model) _____
At what age did your child begin using hearing aids? _____
Does your child currently use hearing aids at: Home - Yes / No
School - Yes / No

Does your child have a cochlear implant (CI)? Yes / No (if Yes, please fill out questions below)

If yes, CI for Right Ear? Yes / No CI for Left Ear? Yes / No
CI manufacturer: Advanced Bionics _____ Med El _____ Cochlear _____

Please list date of surgery and hospital: _____
Where does your child currently receive CI mapping services:
_____
Does your child wear the CI consistently? Yes / No (If no, explain when the CI is used)
_____
Were there any complications during the CI surgery? Yes / No (If yes, please explain)
_____

V. Communication

How do you and your child communicate at **home**? (Check all that apply)

___ ASL ___Sign and speech together at the same time ___Cued Speech ___Oral/Aural
___ Gestures ___Finger spelling _____Signed English (PSE, SEE) ___Homemade signs
___Other (describe)_____

How successful is your child's communication at home? _____
_____

What is your child's preferred method of communication in the **classroom**?

___ASL ___Sign and speech together at the same time ___Cued Speech ___Oral/Aural
___Other (describe)_____

How successful is your child's communication at school? _____
_____

Is your child's speech easily understood by family members? Yes / No

Can people unfamiliar with your child understand his/her speech? Yes / No

What do you feel is your child's best mode of communication? _____
_____

What are your concerns, if any, do you have about your child's communication skills?
_____
_____

VI. Educational History

A. Parent-Infant Program/Early Intervention Services/Family Education:

Schools attended	Address	Dates	Age	Program

B. Elementary:

Schools attended	Address	Dates	Age	Program

C. Middle:

Schools attended	Address	Dates	Age	Program

D. High School:

Schools attended	Address	Dates	Age	Program

VII. Miscellaneous

What characteristics (i.e., happy, sad, shy, active, etc.) best describe your child?

What are your child's learning strengths?

What are your child's favorite hobbies or activities?

What concerns, if any, do you have for your child's learning?

What concerns, if any, do you have regarding your child's behavior and/or social-emotional development?

Name of person(s) completing this case history: _____

Signature(s): _____

Relationship to Student: _____