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FOSTERING INDEPENDENCE

Pathfinder Academy

I. FAMILY HISTORY

Child's Name: _____
(first) (Middle) (Last)

Primary Diagnosis: _____

School District: _____

Sex: ____ **Age:** ____ **Date of Birth:** ____/____/____ **Social Security Number:** ____/____/____

Childs's Medicaid Eligibility: Yes ☐ _____ No ☐ Unknown ☐
(Medicaid Number)

Phone#: _____-_____-_____

Home Address:_____

_____, _____ _____
City State Zip Code

Child lives with: Father ☐ Mother ☐ Both ☐ Guardian ☐

Name: _____ **Age:** _____ **Home Phone:** _____-_____-_____

Occupation: _____ **Work Phone:** _____-_____-_____

Name: _____ **Age:** _____ **Home Phone:** _____-_____-_____

Occupation: _____ **Work Phone:** _____-_____-_____

List all siblings:

Name	Sex	Age	Grade	Lives in home with the child	
_____	___	___	_____	Yes ☐	No ☐
_____	___	___	_____	Yes ☐	No ☐
_____	___	___	_____	Yes ☐	No ☐
_____	___	___	_____	Yes ☐	No ☐

Do any other family members have special needs? Yes ☐ No ☐

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II. MEDICAL HISTORY

Has child been treated for : Vision loss? Yes ☐ No ☐ If yes, when? _____ Where? _____

Hearing loss? Yes ☐ No ☐ If yes, when? _____ Where? _____

What were you told at these visits: _____

_____

Any Problems: During Pregnancy? Yes ☐ No ☐

Please explain_____

_____

During delivery? Yes ☐ No ☐

Please explain: _____

_____

Was labor induced? Yes ☐ No ☐ If yes, please explain: _____

_____

Weeks gestation? _____

Child's health at birth: _____

Birth height/weight: _____ht/_____wt

Describe your child's development and indicate age at each of the different developmental milestones:

Was weaned (bottle/breast): _____ Made sounds (coo/babble):_____, sound:_____

Sat alone: _____ Crawled: _____, describe:_____

Walked alone: _____ Run: _____

Ride a bike: _____ Swim: _____

Toilet Train: _____

Is your child understood by parents/guardians? Yes ☐ No ☐ If yes, explain: _____

Is your child understood by others? Yes ☐ No ☐ If yes, explain: _____

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List your developmental concerns: _____

_____

_____

_____

Has your child been diagnosed or treated for:

ADD/ADHD:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Allergies:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Asthma:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Cancer:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Cleft Palate:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Cerebral Palsy:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Diabetes:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Infections:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Operations:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Seizures:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Tubes in ears:	**Yes ☐**	**No ☐**	**If yes, explain:** _____
Other:_____	**Yes ☐**	**No ☐**	**If yes, explain:** _____

Is your child on any kind of medication? Yes ☐ No ☐

If yes, name of medication as written on the Rx or bottle label:_____

_____

High fevers (104 degrees or higher): Yes ☐ No ☐ Duration: _____

Childhood diseases (measles, mumps, etc.): _____

_____

Check and list any of the following with whom you have had contact concerning your child:

	Name	**Address**
☐ **Pediatrician:**	_____	_____
	Telephone: _____-_____-_____	_____
☐ **Primary Care Doctor:**	_____	_____
	Telephone: _____-_____-_____	_____

☐ **Dentist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Orthopedist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Ear, Nose, and Throat Specialist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Ophthalmologist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Surgeon:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Psychiatrist/Psychologist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Audiologist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Speech Pathologist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Occupational Therapist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Physical Therapist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Social Worker:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Dietician, Nutritionist:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Targeted/Certified Case Manager:** _____ _____

Telephone: _____-_____-_____ _____

☐ **Others (specify):** _____ _____

Telephone: _____-_____-_____ _____

III. BEHAVIOR

Please describe your child's personality (activity level, affectionate, shy, noisy, fearful, ect.):

_____

_____

Does your child display behavior difficulties? Yes ☐ No ☐ If yes, explain:

_____

_____

_____

temper tantrums? Yes ☐ No ☐ If yes, describe:

_____

_____

Describe how your child relates to others:

Other children? _____

Other Peers? _____

Adults?_____

Do you see any serious behavior problems with your child? Yes ☐ No ☐ If yes, please explain:

_____

_____

What is the frequency of these behaviors? Daily ☐ Weekly ☐ Monthly ☐

Any odd or unusual behaviors? Yes ☐ No ☐ If yes, please explain

_____

_____

What discipline do you use with your child? Spanking ☐ Time-out ☐ Other ☐

_____

_____

How often has the family moved in the last year? _____ **Since birth?** _____

Has the child ever lived away from the family? Yes ☐ No ☐ If yes, explain

_____

_____

Have there been any significant deaths in the child's life? **Yes ☐** **No ☐** **If yes, explain**

_____

_____

Any history of psychiatric illness in the immediate family? **Yes ☐** **No ☐** **If yes, explain**

_____

_____

History of substance abuse in the family? **Yes ☐** **No ☐** **If yes, explain**

_____

_____

_____

Has the child ever been a victim of sexual abuse? **Yes ☐** **No ☐**

Has the child ever been a victim of physical abuse? **Yes ☐** **No ☐**

Has the family had any involvement with DHS? **Yes ☐** **No ☐** **If yes, explain**

_____

_____

_____

_____

What are the major family stressors at this time? (divorce, parenting, death, loss of job, etc.

_____

_____

_____

_____

What is the child's current support system:

Family	**☐ Paternal**	**☐ Maternal**
Relatives	**☐ Paternal**	**☐ Maternal**
Friends	**☐ Paternal**	**☐ Maternal**

Church ☐

_____

_____

Comments/Other Information

_____

_____

_____

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IV. EDUCATIONAL HISTORY

A. Please list all schools your child has attended, beginning with any nursery or daycare before kindergarten, and ending with your child's current school.

SCHOOL	ADDRESS	GRADE OR CLASS PLACEMENT(S)	DATES OF ATTENDANCE

B. Previous grade retention(s)? _____ *(please specify)*

***** Please attach copies of any previous test results, if available. *****

C. Has your child ever been evaluated before? Such as by the school, a clinic, or a speech-pathologist?

Yes ☐ No ☐ If yes, where and when? _____

_____

_____

_____

D. Has your child ever received specialized services such as speech-language, occupational therapy, physical therapy, or academic services? Yes ☐ No ☐ If yes, please specify: _____

_____

_____

_____

_____

_____

_____

V. FEEDING AND SWALLOWING HISTORY

Was the child breast-fed? Yes ☐ No ☐ If yes, for how long? _____

_____
_____
_____
_____

Were there any difficulties?

_____
_____
_____
_____

Was the child ever fed through a feeding tube? Yes ☐ No ☐
If yes, explain why, What type of tube and the duration:

_____
_____

Describe nutritional intake in a typical day.
Include time of day, duration of meal, food consumed and amount consumed per meal.

_____
_____
_____
_____

Is any adaptive equipment used? (Maroon Spoon, cut out cup, etc) Yes ☐ No ☐ If yes, please specify:

_____
_____
_____
_____

List food likes and dislikes.

_____
_____
_____
_____

List foods that the child has difficulty eating or drinking.

_____
_____
_____

Does the child take nutritional supplements. **Yes ☐** **No ☐** **If yes, please describe:**

_____
_____
_____
_____

Does the child drool? **Yes ☐** **No ☐** **If yes, how often?**

_____
_____
_____
_____

How does the child let you know if he or she is hungry.

_____
_____
_____
_____

How does the child let you know he or she is full?

_____
_____
_____
_____

In general, are mealtimes a pleasant experience? **Yes ☐** **No ☐** **If no, Please explain:**

_____
_____
_____
_____

Please describe any other observations or concerns about the child's feeding and swallowing status.

_____
_____
_____
_____
_____
_____
_____

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VI. SELF CARE ASSESSMENT

Please let us know how your child does on these tasks using the following rating scale:

I = the child will do it by themselves
A = the child will do it with a little help
D = the parent does most of the task for the child
N/A = we have never tried to do this task with our child

DRESSING

_____	Underwear/bra	_____	socks	_____	snaps
_____	Pants/shorts	_____	shoes	_____	tie shoes
_____	t-shirt	_____	buttons	_____	zippers
_____	jacket	_____	picks out appropriate clothes		

TOILETING/BATHING

_____	uses by self when needed	_____	goes when asked	_____	washes hands
_____	verbalizes the need to go	_____	manages clothing by self	_____	washes body
_____	wipes thoroughly	_____	gets own soap/shampoo	_____	washes hair
_____	uses public restroom by self	_____	adjusts water temp by self	_____	dries self

GROOMING

_____	brushes hair	_____	trims or files fingernails	_____	washes face
_____	puts on deodorant	_____	manages tangles	_____	brushes teeth
_____	washes and dries hands thoroughly (front and back)			_____	puts on toothpaste

EATING:

_____	eats a variety of healthy foods	_____	uses knife to cut foods
_____	uses fork/spoon	_____	drinks from an open cup without spilling

CLOTHING:

_____	puts dirty clothes in hamper	_____	sorts clothes	_____	fold towels
_____	runs washer/dryer	_____	puts clean clothes away in correct places		
_____	folds clothing	_____	hangs clothes on hanger in closet		

COOKING:

_____ pours drink into cup without spilling
_____ can make a cold meal (sandwich, bowl of cereal)
_____ can make a simple meal in the microwave (easy Mac, frozen entrée)

CLEAN-UP:

_____	wipes counters thoroughly	_____	dries dishes	_____	sweep floors
_____	washes dishes	_____	put away dishes	_____	mop floors
_____	vacuum				

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OTHER INFORMATION:

Please take the time to share any other information you would like us to know about your child, frustrations and successes.

_____
_____
_____
_____
_____
_____

_____ _____

Signature of person completing this form **Date completed**

_____ _____

Printed name of person completing this form **Relationship to Student**

Updates:

Date:	Signature: