

FAMILY Siblings:

<u>Names</u>	<u>Date of Birth</u>	<u>Education</u>	<u>Regular Classes</u>	<u>Special Ed.</u>	<u>Health</u>
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Has any other child been treated by a psychologist or psychiatrist for any emotional problems

Other Agencies student is known to _____

PARENT COMMENTS

View on placement _____

Goals of parents for child _____

Future plans after completing program and returning home _____

Weekend and vacation plans _____

Transportation plan _____

PERSONALITY TRAITS

General description of behavior _____

Recreation – types of hobbies, interests, sports, etc. _____

Sleeping problems _____

Does student ever attempt to leave a group or run from home _____

Has student ever stayed overnight away from home or lived at residential school _____

VOCATIONAL HISTORY/abilities – programs/employment

SEXUAL BEHAVIOR AND KNOWLEDGE

Any knowledge of sexual matters _____ Any interest in opposite sex _____

Describe _____

Self Help Skills _____

Communication Skills _____

Strengths _____

Areas of need _____

Any know or suspected history of physical or sexual abuse:

As a victim? _____

As an abuser of others? _____

SPECIAL SERVICES (present)

Speech _____

Occupational Therapy _____

Physical Therapy _____

Counseling _____

Other _____

COMMENTS _____

MEDICAL INFORMATION: Name _____ DOB: _____

first middle last

Diagnoses: 1. _____ 2. _____

Sex: M _____ F _____ Are Menstrual Cycles Regular _____ Ht. _____ Wt. _____

Allergies: Food _____ Medicine _____ Seasonal _____

SEIZURES: Yes _____ No _____ Are they controlled _____

MEDICATIONS: Name Amount Frequency

Prescribing Physician _____ Address _____

Phone _____ FAX _____

Dentist _____ Address _____

Phone _____ FAX _____

Orthodontist _____ Address _____

Phone _____ FAX _____

Medical Coverage _____ # _____

Toileting Skills _____

Recent Hospitalizations, illness _____

Does the student receive psychiatric treatment of hospitalization?

When _____

Where _____

Has the student used alcohol or drugs? _____

Has the student displayed any behaviors harmful to self or others? _____

Does student have any physical handicaps _____

Need for Physical Therapy Yes _____ How often _____ No _____

Other pertinent medical information: _____

Is your child capable of recognizing danger and removing him/herself from the situation i.e., in case of fire (self preservation) _____