FORM B

CAR O LI NA TANAUAN INTERVENTION CENTER INC.,

130 F. Onate St., 2 Tanauan City
043-784-24-08

Date_____

NAME OF STUDENT_____

Sex_____ Age_____ Date of birth _____ Birth Order_____

Referred by_____

Copy of Doctor Evaluation/Report [ ] available [ ] not available

FAMILY BACKGROUND

A. **Parents**

	MOTHER	FATHER
Name		
Home Address		
Contact nos. Work		
Home		
Mobile No.		
Any known disability		

B. Siblings

	SISTERS	BROTHERS
Birth Order		
Age		
Any known disability		

C. Languages spoken at home _____

D. People living in the house other than family _____

Pregnancy

Number of previous pregnancy _____
Number of live birth _____
Was the mother under regular parental care? [ ] YES [ ] NO
Any illness during pregnancy? [ ] YES [ ] NO
If yes, describe briefly. _____
Any injuries sustained during pregnancy? [ ] YES [ ] NO

If yes, describe briefly. _____
Medication used, if any. _____
Period of hospitalization? _____

Delivery

Was the baby full term?	[ ] YES	[ ] NO
Normal delivery?	[ ] YES	[ ] NO
Breeched (suhi) delivery?	[ ] YES	[ ] NO
Caesarian section?	[ ] YES	[ ] NO
What anesthesia was used, if any?	[ ] YES	[ ] NO
	_____	
Did the baby suffer from lack of oxygen?	[ ] YES	[ ] NO
Did the baby cry right away?	[ ] YES	[ ] NO
Baby's birth weight	_____	

Developmental Milestones

Gross Motor Skills	***Months/Age***
Prone	_____
Supine	_____
Rolling	_____
Creeping	_____
Sitting	_____
Standing	_____
Walking	_____
Stair climbing	_____
Jumping	_____
Hopping	_____

Feeding

Did the child suck readily?	[ ] YES	[ ] NO
Is the child breast-fed?	[ ] YES	[ ] NO
For how long?	_____	
Any gastro-intestinal disturbances?	[ ] YES	[ ] NO
Any milk allergies?	[ ] YES	[ ] NO
Age when the baby was weaned from bottle?	_____	

Toilet training

Is the child toilet-trained?	[ ] YES	[ ] NO
Does the child still wear diapers?	[ ] YES	[ ] NO
If yes, when did the toilet training begin?	_____	
When did the baby get toilet-trained?	_____	

What sign does the child give to indicate toilet needs? _____

Medical History
Check the illnesses the child has had.

DISEASE	AGE CONTRACTED
[ ] Measles	_____
[ ] Whooping Cough	_____
[ ] Mumps	_____
[ ] Chicken Fox	_____
[ ] Rheumatic Fever	_____
[ ] Polio	_____
[ ] Others	_____

Any change in child's behavior after the illness [ ] YES [ ] NO
If yes, please describe. _____

What immunizations have been given to the child?

[ ] BCG	[ ] Hepatitis A
[ ] DPT	[ ] Hepatitis B
[ ] Polio	[ ] Typhoid
[ ] Measles	[ ] Tuberculin
[ ] Influenza	[ ] Varicella
[ ] MMR	[ ] OPV

Has the child ever been hospitalized? [ ] YES [ ] NO
If so, why? How long? _____
Has oxygen ever been administered to the child? [ ] YES [ ] NO
If so, under what circumstances? _____
Has the child ever lost consciousness? [ ] YES [ ] NO
If so, for how long? _____
Has the child had convulsions? [ ] YES [ ] NO
Seizures? [ ] YES [ ] NO
Any accidents that involved head injuries? [ ] YES [ ] NO
If so, please describe? _____

Does the child have any:

Visual problem? Describe briefly. [ ] YES [ ] NO_____
_____

Hearing problem? Describe briefly. [ ] YES [ ] NO_____
_____

Touch problem? [ ] Hypersensitive [ ] Hyposensitive
[ ] Tolerates handling [ ] Difficulty tolerating handling

Proprioceptive problem? [ ] Responds appropriately to input [ ] seeks out input

Movement problem? [ ] Tolerates imposed movement [ ] Difficulty tolerating imposed movement

Child's Present Physical Condition

Hand preference [ ] Left [ ] Right [ ] Both
Any problem in hand coordination? [ ] YES [ ] NO
Describe briefly. _____
Does he/she drool? [ ] YES [ ] NO
Does he/she have normal breathing pattern? [ ] YES [ ] NO
Allergies? [ ] YES [ ] NO

Childs Present Behavior

PLAY

Indoor play activities _____
Outdoor play activities _____
Imaginary play _____
Watching television _____
Most activities enjoyed _____

SLEEP

What time does the child go to bed? _____
Does the child sleep soundly? [ ] YES [ ] NO
Does he/she sleep at regular hours? [ ] YES [ ] NO
Average number of hours of sleep? _____
With whom does he/she sleep? _____
Does he/she take naps? [ ] YES [ ] NO
How long? _____

EATING

Favorite food _____
Most disliked food _____
Any eating problems? [ ] YES [ ] NO
Describe briefly _____
Can the child feed himself? [ ] YES [ ] NO
Is the child's meal prepared on demand? [ ] YES [ ] NO
Does he/she eat with the rest of the family? [ ] YES [ ] NO
Any problem in swallowing? [ ] YES [ ] NO
In chewing? [ ] YES [ ] NO
Does the child gag? [ ] YES [ ] NO
What utensils can he/she use? _____
Any major eating concerns? _____

HABITS

Is the child attached to any particular object? [ ] YES [ ] NO
If so, what? _____
Noticeable mannerisms: [ ] Thumb sucking [ ] Head banging
[ ] Hand flapping [ ] Others _____

CHANGE IN BEHAVIOR

Self Stimulatory:	[ ] head banging	[ ] pill rolling	[ ] rocking
	[ ] swaying	[ ] hand flopping	[ ] ears covering
Self regulation:	[ ] calm	[ ] tantrums frequently	[ ] difficult to calm

Cognitive

Does the child know his/her alphabet?	[ ] YES	[ ] NO
Can the child read?	[ ] YES	[ ] NO
Can the child count?	[ ] YES	[ ] NO
Can the child recognize colors?	[ ] YES	[ ] NO
Can the child recognize shapes?	[ ] YES	[ ] NO

Psychological history of the child

1. Has the child had any psychological examination? If so, give date and summary of the results. If possible, provide a copy of the results.

_____

_____

2. Parent to whom the child is more attached. _____
3. Was it always the case? _____
4. Have there been any sudden separations in the immediate family? _____
5. When did the parents start being concerned with the child's behavior? _____
6. What type of behavior did the child exhibit that alarmed the parents?

_____

Educational history of the child

1. Age when the child first entered the school? _____

Schools attended

Name of school	Dates Attended
_____	_____
_____	_____
_____	_____

2. Reasons for withdrawal _____
3. Are there other information you want to disclose to help the Center in designing and planning the program for your child?

_____

_____

_____ _____

SIGN OVER PRINTED NAME DATE