File Number	TYPE OF DISABILITY	Future action:	Date:	Done:
Code	Movement _____			
	Deformity _____			
	Cognitive delay _____	_____ come back again	_____	_____
	Visual impairment _____			
	Hearing loss _____	_____ refer to specialist	_____	_____
	Speech _____	_____ visit at home	_____	_____
	Seizures _____			
	Behavior _____	_____ other _____	_____	_____
	Other _____			

Specific disability if known: _____

RECORD SHEET 1 (page 1)

CHILD'S HISTORY (First visit)

Name: _____ Sex:

Date of birth: _____ Address: _____

Age: _____ Weight: _____ Height: _____ _____

Mother: _____ _____

Father: _____ Telephone: _____

How did you learn about the program? _____

WHAT IS THE CHILD'S MAIN DISABILITY? _____

_____

_____

When did it begin? _____ How? (Cause?) _____

Other disabilities? _____

Is the disability improving? _____ Getting worse? _____ About the same? _____

Explain: _____

How do you hope your child will benefit from coming here? _____

Do other family members or relatives have a similar disability? _____ Who? _____

Has the child received medical attention? _____ What? _____

_____ Where? _____

Use any braces or other aids? _____ What? _____

Has the child used any in the past? ____ Explain: _____

_____

How is the child's general health? _____

Is the child overweight? _____ Malnourished? _____ Other? _____

Hears and sees well? _____ Explain: _____

Comment on the child's developmental abilities or difficulties: typical for age?

- head control _____ _____
- use of hands _____ _____
- creeping or crawling _____ _____
- standing, walking _____ _____
- play _____ _____
- feeding or drinking _____ _____
- toileting _____ _____
- personal hygiene _____ _____
- dressing _____ _____

Does the child speak? _____ How much or well? _____ Began when? _____

What other things can the child do? _____

_____

What things can the child not do? _____

_____

What new skills or abilities would you like to see your child gain? _____

_____

RECORD SHEET 1 (page 2)

Is the child mentally typical? _____
Cognitive delay? __ How severe? _____
Why do you think so? _____
Does the child have seizures? _____ How often? _____
Describe: _____
Takes medicine? _____ What? _____
For what? _____ Results (good or bad): _____
Behavior typical for age? _____
Behavioral or emotional problems? _____ Explain: _____
_____
_____
Goes to school? _____ What year? _____
With whom does the child live? _____
Number of brothers and sisters: _____ Ages: _____
Father works? _____ At what? _____
Mother works? _____ At what? _____

AVERAGE EARNINGS

The child seems: well-cared for? _____ spoiled or overprotected? _____
neglected? _____ happy? _____ self-confident? _____ withdrawn? _____
other? _____
Important details of family situation: _____
_____
_____
What has the family done, made, or obtained to help the child function better? _____
_____
Other observations, information or drawings:
(Use an additional sheet if necessary.)
_____
_____
_____
_____
_____
_____
_____

History of illness	Date
measles	_____
chicken pox	_____
whooping cough	_____
other _____	_____
_____	_____

Vaccinations:	How many	Dates	Allergies
BCG (TB)			
polio			
DPT			
Hep B (Hepatitis B)			
measles			
tetanus			
other			

How much have you spent for your child's disability? _____ For what? _____
_____
Were disability or complications caused by improper medical treatment or therapy? _____
Explain: _____

FOR CHILDREN WITH PARALYSIS:
Was your child injected before becoming paralyzed? _____