hugs. hope. help.
harwood
Little Kids With Special Needs

GETTING TO KNOW YOUR CHILD

Date: _____

Child's Name: _____
(Last) (First) (MI)

Family Information

Household members:

1. _____
(Name) (gender) (Age) (Relationship to child)

2. _____
(Name) (gender) (Age) (Relationship to child)

3. _____
(Name) (gender) (Age) (Relationship to child)

4. _____
(Name) (gender) (Age) (Relationship to child)

5. _____
(Name) (gender) (Age) (Relationship to child)

6. _____
(Name) (gender) (Age) (Relationship to child)

Current or Previous Preschool/Childcare Placements

Name of School: _____
Days and hours: _____
Address/Phone: _____

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Days and hours: _____
Address/Phone: _____

Diagnosis: _____

Diagnosed by: _____ Date_____

Allergies-Types and Treatment

_____
_____
_____

- Epi-Pen
- Breathing machine
- Other: _____

Seizures-Types and Treatment

_____
_____

Special Equipment/Procedures

- Walker
- Special Chair-Rifton, corner, etc.
- Feeder Seat
- Hand Splints
- Stander-supine or prone
- Wheelchair
- Helmet
- Braces
- Other: _____

If you have checked any of the above, we will need to have a form completed by your child's therapist and/or physician with orders for treatment and/or for using the equipment required.

Self Help Skills

Toileting: (diapers, pull-ups, training pants, beginning to train, comments, etc):

- Diapers or pull-ups
- Underwear or training pants
- Beginning to train

Comments: _____

Feeding:

- Sippy cup
- Open cup
- Self-feed finger food
- Self-feed with utensils

Comments (list any likes and dislikes):_____

Dressing/Grooming:

- Puts on clothes
- Takes off clothes
- Washes hands
- Cleans face with napkin
- Blows nose

Sleeping:

- Sleeps through the night How long? _____
- Naps during the day How long? _____

Communication:

- Uses words & vocalizations
- Sign-language
- Augmentative Communication Device (iPad; prolquo2go; hip talk, etc.)
- PECS
- Gestures

Please explain how your child expresses his/her wants and needs:_____
_____
_____

Please tell us what helps to calm or soothe your child: _____
_____
_____

Favorite Activities and Games: _____
_____
_____

Favorite Toys: _____
_____
_____

BEHAVIORS

Please describe any unusual or difficult behaviors:

Non-compliance: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Tantrums: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help:_____
_____

Aggression: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Repeating mannerisms (hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, etc.):
Describe_____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Unusual attachment to certain things: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Repeating words or sounds: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Difficulty with transitions or changes in routine: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Unusual interest in the sight, feel, sound, or smell of things: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Preoccupations/obsessions (anything done repeatedly): □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Fears or aversions to certain things: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

Other: □ yes □ no
Describe _____
Frequency (daily, weekly, monthly): _____
Strategies used to help: _____
_____

PREVIOUS AND CURRENT SERVICES

(Speech Therapy, Occupational Therapy, Physical Therapy, Behavioral Therapy, etc.)

Type of Treatment and Name of Provider:_____
Duration of Treatment: _____
Child's age during treatment: _____
Effectiveness of treatment: _____

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