Related Services Case History
Plainfield Public Schools

Childs Name: _____ Birthdate: _____ ☐ Male ☐ Female

Birth History

How many weeks was the pregnancy? _____

Was there anything unusual about the pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Medical History

Has your child had any of the following?

☐ Adenoidectomy

☐ Allergies

☐ Breathing difficulties

☐ Ear Infections

How Often_____

☐ Ear Tubes

☐ Encephalitis

☐ Head injury

☐ Seizures

☐ sleeping difficulties

☐ Thumb/finger sucking habit

☐ Tonsillectomy

☐ Vision problems

Wears glasses ☐ Yes ☐ No

Other serious injury/surgery: _____

Other diagnosis: _____

Developmental History

Please tell the age your child achieved the following developmental milestones:

_____sat alone

_____ babbled

_____ put two words together

_____ walked

_____grasped crayon/pencil

_____ said first words

_____ spoke in short sentences

_____ toilet trained

Does your child brush his/her teeth and/or allow brushing ☐ Yes ☐ No

Additional History

Was child ever referred for Birth to Three services? ☐ Yes ☐ No

If yes:

By who? _____

Why? _____

Were you able to access these services? ☐ Yes ☐ No

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Who speaks the language? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language ☐ Yes ☐ No

Which language does the child prefer to speak at home? _____