Service Coordination/Case Management
Individual/Family History

I IDENTIFYING DATA:

Name: _____ Date of Report: _____

Placement Type: _____ Individual No: _____

Address: _____ Date of Birth: _____
Street

Age: _____

_____
City, State Zip Home Phone: _____

_____ Work Phone: _____
County

Sex: _____ Race: _____ Marital Status: Married _____

Height: _____ Weight: _____ Religious Preference: _____

Legal Status/Guardianship Appointed: ☐ yes ☐ no

II. REFERRAL INFORMATION:

Reason for Referral: _____

Referral Source: _____

Date of Referral: _____

III. ASSESSMENT INFORMATION:

IQ Test Name/Date: _____

FSIQ Score/Level: _____

ABS Level/Date: _____

IV. INDIVIDUAL FINANCIAL INFORMATION:

Source of Income: _____ Gross Monthly Income: _____

Medicaid Waiver (Type): _____ Housing: _____

Medicaid Number: _____ Food Stamps: _____

Medicare Number: _____ ADC: _____

Payee(if other than individual): _____ WIC: _____

Other Insurance: _____ EPSDT Screening: _____
(Yes, NO, N/A)

V. FAMILY HISTORY/RELATIONSHIPS:

A. Marital Status of Natural Parents: (Check One)

☐ Married ☐ Separated ☐ Divorced ☐ Never Married ☐ Widowed

B. Information on Father

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Place of Birth: _____

SSN: _____ Source of Income: _____

Occupation/Place of Employment: _____

Number of Years of Education: _____ Veteran: ☐ Yes ☐ No

If Deceased, Date and Cause of Death: _____

C. Information on Mother

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Place of Birth: _____

SSN: _____ Source of Income: _____

Occupation/Place of Employment: _____

Number of Years of Education: _____ Veteran: ☐ Yes ☐ No

If Deceased, Date and Cause of Death: _____

D Contact Person

I. Contact person's name and related information (if different from natural parents) or parent's address and related information (if different from individual).

(Name) (Relationship) (Phone)

(Address) (City) (County) (State) (zip)

2 Emergency contact person (other than parents/contact person).

(Name) (Relationship) (Phone)

(Address) (City) (County) (State) (zip)

E. Brothers and Sisters and/or children of Individual:

Name	Relationship (Bro./Sis/Child)	Date of Birth	Sex	Address/Citv/State

F. Sources of Family Support (Immediate and Extended):

G Other Sources of Support (Friends, Agencies, Sponsor, Advocate, Guardian):

H. Family Medical History:

Condition	Relationship to Individual
☐ Heart Disease	_____
☐ Diabetes	_____
☐ Mental Retardation	_____
☐ Cancer	_____
☐ Mental/Emotional Disorders	_____
☐ Vision Problems	_____
☐ Hearing Problems	_____
☐ Genetic Disorder	_____
☐ _____ (Other)	_____
☐ _____ (Other)	_____

VI. PRENATAL/DEVELOPMENTAL/HEALTH HISTORY:

A. Pregnancy History/Maternal Factors:

No of this pregnancy ___ Prenatal care received ☐ Yes ☐ No

Medications taken during pregnancy: _____

_____

Infections/lllnesses/Accidents during pregnancy (describe):

_____

_____

_____

B. Birth History:

Length of labor _____ Anesthesia Used ☐ Yes ☐ No

Type of delivery: ☐ Natural ☐ Caesarean Birth weight _____

Place of delivery_____ Condition at birth _____

Problems breathing ☐ Yes ☐ No Oxygen used ☐ Yes ☐ No

Jaundiced ☐ Yes ☐ No Normal cry ☐ Yes ☐ No

Name of delivery physician_____

If premature, number of weeks of gestation: _____

C. Developmental Milestones(Age):

Held head erect	_____	Pulled to standing	_____
Rolled over	_____	Stood alone	_____
Sat alone	_____	Walked without holding	_____
Crawled	_____	Toilet trained	_____
Said single words	_____	Used 2-3 word phrases	_____

D. Immunizations: _____

_____

_____

Where is immunization record filed: _____

E. Dental History:

1. Ever seen by dentist: ☐ Yes ☐ No
2. Name of dentist: _____
3. Date last seen by dentist: _____

F. Has Individual Had Any of the Following? If so, explain details:

1. Accidents: _____

_____

2. Hospitalizations: _____

_____

_____

3. High Fever (cause unknown): _____
4. Pneumonia: _____
5. Anemia: _____
6. Kidney or Urine Infection: _____
7. Constipation/Diarrhea: _____
8. Vision Problems: _____
9. Hearing Problems: _____
10. Ear Infections: _____
11. Movement Problems (equipment). _____

_____

_____

12. Skin Disease/Abnormality: _____
13. Allergies: _____

14. Seizures: _____

a. When started: _____

b. How often: _____

c. What type: _____

d. What medications for control: _____

_____

15. Ingestion of Toxins/Poisons Such as Drugs, Cleaners, etc.:

_____

16. Other Illnesses: _____

G. List Medications Individual Is Currently Taking: _____

_____

_____

_____

H. Current Diet (check one):

☐ Regular ☐ Chopped ☐ Blended

☐ Other _____

I. List Below Names of Places Where Individual Has Received Care (Public Health Nurse Services, Children's Rehabilitation Conic, Department of Human Resources, mental health center, medical specialist, psychologist, psychiatrist, etc.) And a Brief Summary of Services Received:

Individual's Physician: _____ Phone # _____

_____

_____

_____

_____

_____

J. Other Residential Placements Away From Parent/Guardian (dates of admission, discharge, or transfer):

_____

_____

_____

_____

VII EDUCATIONAL/VOCATIONAL HISTORY:

Educational History:

Previously/Presently enrolled in program: ☐ Yes ☐ No

Name of School/Training Program	When started	Length of Stay

Employment History:

Place of Employment	Date Employed	Job Title/Dutles

VIII. Recommendations:

Completed By:

Name

Title