



Case # _____

Date _____

CHILD'S MEDICAL HISTORY AND DISABILITY REPORT
(Please Print)

Name: _____

Address: _____

Phone: _____

Social Security Number: _____

To assist in the disability determination, please attach any documentation about the child's condition that you have.

I. INFORMATION ABOUT YOUR CONDITION

A. What is your child's disabling condition? Briefly describe the disabling illness or Injury. _____

B. When did your child become disabled? (MM/DD/YY)

C. Has your child worked since he/she became disabled? YES NO

D. Explain how your child's condition affects him/her and keeps him/her from performing daily activities. _____

II. INFORMATION ABOUT YOUR TREATMENT

Give the name, address, and telephone number of medical providers, hospitals, or clinics

Where your child has received treatment for the condition(s) that disabled him/her.

A. _____

Name of physician/facility

Dates first/last treated

Address

Phone number

B. _____

Name of physician/facility

Dates first/last treated

Address

Phone number

C. _____

Name of physician/facility

Dates first/last treated

Address

Phone number

D. _____

Name of physician/facility

Dates first/last treated

Address

Phone number

E. _____

Name of physician/facility

Dates first/last treated

Address

Phone number

III. Has your child been seen by other agencies for his/her disabling condition? (VA, Vocational Rehabilitation, Social Security, etc.)

YES _____ NO _____

If YES, please complete the following.

NAME OF AGENCY ADDRESS PHONE

NAME OF AGENCY ADDRESS PHONE

NAME OF AGENCY ADDRESS PHONE

IV. MEDICAL/MENTAL TESTS

Has your child had any of the following tests in the last 2 years?

Electrocardiogram _____ Chest X-ray _____ X-rays (other) _____ Blood tests _____

Pulmonary test _____ MRI/CT _____ Mental test _____ Psychological test _____

V. MEDICATION YOUR CHILD IS TAKING OR HAS TAKEN IN THE LAST 2 YEARS.

VI. EDUCATION LEVEL

What is the highest grade your child has attended? _____

Name and address of school

Dates attended

Name and address of school

Dates attended

Does the child read, write, or speak English?

YES _____ NO _____

If NO, what language? _____

VII. ACTIVITIES (If more space is needed, use a separate piece of paper.)

A. Is the child able to care for personal needs (bathing, dressing, toileting, toothbrushing, hair brushing, etc.)? Are there any special problems in this regard?

B. Describe the child's daily activities. Start from the time the child wakes up and describe a typical day until he/she goes to bed. List the limitations in activities that your child has compared to his or her playmates of the same age. Give specific examples.

C. What does the child do when he/she is not in school? How long and how often does he/she do these things?

D. Is the child expected to help with household chores? If yes, what are the chores? How often are they done? How well are they done? How much supervision is required?

E. Describe the child's friends and playmates; their ages, activities, how often, and how they play together. Please list the limitations in activity your child experiences as compared to his or her playmates of the same age. Give specific examples.

F. How well does the child behave with adults (parents, other family members, teachers, and neighbors)? Please give examples.

G. How many other children live with this child? What are their ages? Describe how the child interacts with them.

H. Describe in full any “problem” behaviors. For example, serious fighting, stealing, bedwetting, withdrawal from others, etc. Also, describe how frequently any of these behaviors occur.

I. Does the child miss school regularly? How often and why?

J. How frequently does your child see a doctor due to illness and how frequently has your child been hospitalized or seen in the Emergency Room in the past year?

VII. ADDITIONAL INFORMATION OR COMMENTS

I understand that my report will be used in conjunction with information provided by my physician and hospital to determine my child's disability claim. This information I have provided is strictly voluntary. Failure to provide all or part of the information requested may affect the determination of my child's claim.

Signature

Date

(This section for agency use only)

1. Interview was conducted face to face with client_____ client's representative_____.
2. Interview was conducted over the phone_____, thru an interpreter_____, thru an agent_____.
3. Client was_____was not_____present at the interview.
4. Client had difficulty with the following:

reading_____	writing_____	answering_____
hearing_____	seeing_____	sitting_____
understanding_____		using hands_____
walking_____		other (specify)_____

Interviewer Signature

Date