

APPENDIX – V
CASE STUDY PROFILE

DOB: ____/____/____ Gender: ____ Standard: ____ Section: ____

Language spoken at home: _____

Address: _____

History of present problem

Events or incidents leading to disabilities: _____

Family History of symptoms: _____

Onset of impairment: _____

Was there a clear time when Sx's worsened? _____

Previous diagnosis (by whom): _____

Course of illness: _____ Improving _ Stable _____ Deteriorating _ Varies

Frequency/Duration/Intensity/Cycling of symptoms: _____

Family Information

Father: _____ DOB: ____/____/____

Mother: _____ DOB: ____/____/____

_____ Nuclear family _____ Single-parent _____ Adopted

_____ Joint family _____ Separated _____ Divorced

Siblings:

1. _____ DOB: ____/____/____

2. _____ DOB: ____/____/____

3. _____ DOB: ____/____/____

4. _____ DOB: ____/____/____

People in household (if different from above):

1. _____ Relationship: _____ Age: _____

2. _____ Relationship: _____ Age: _____

3. _____ Relationship: _____ Age: _____

4. _____ Relationship: _____ Age: _____

What are the academic problems/issues the student faces? _____

Is he/she able to:

Follow instructions at school? YES / NO

Complete assignments on time? YES / NO

Seems to have friends at school? YES / NO

Remember school assignments? YES / NO

Is the student receiving help from outside?

Is the student trying HARD / AVERAGE / VERY

YES / NO

LITTLE in school?

Does the student receive help from outside of school? Please specify _____

What do the teachers have to say about the student? Specify _____

How is the student in the following areas?

Area	Above Average	Average	Below average
Concentration			
Attention			
Organization			
Listening			
Understanding instructions			

Complaints of behavior problems, if any?

Medical History

During the pregnancy, did the mother use ALCOHOL / DRUGS / CIGARETTES / HAVE MENTAL STRESS? Specify frequency, amount, and duration. _____

List any birth complications (eg. Forceps, premature, c-section, etc): _____

List any medical condition or history (eg. Allergies, broken bones, hospitalizations, loss of consciousness, etc): _____

How much time does the child spend on the following activities in a week

Internet: _____

Reading: _____

Television: _____

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Other activities: _____

Self-help Skills (Describe child's ability and assistance needed in the following)

Dressing: _____

Grooming: _____

Feeding self: _____

Avoiding dangers: _____

Independent activities outside the home: _____

Taking the bus: _____

Has your child ever been verbally abused? ☐ YES ☐ NO ☐ SUSPECTED Specify: _____

Has your child ever been physically abused? ☐ YES ☐ NO ☐ SUSPECTED Specify: _____

Has your child ever been sexually abused? ☐ YES ☐ NO ☐ SUSPECTED Specify: _____

What are your child's strengths? _____

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Briefly, what are your goals for your child in counseling? _____