

CATHOLIC FAMILY CONFERENCE

Special Needs Form-Children and Teens

Name _____ M _____ F _____

Birth Date _____ Chronological Age _____ Mental Age _____

Disabilities _____

Address _____
Street _____ City _____ State _____ Zip _____

Person Attending conference who is responsible for this individual _____

SOCIAL RELATIONSHIPS AND BEHAVIORAL INFORMATION

Does this individual have difficulty with:

___ Meeting New People _____

___ Working with Others _____

___ Sharing _____

___ Expressing Affection _____

___ Strong Emotional Attachments _____

___ Stubbornness _____

___ Being Overly Affectionate _____

___ Sexual Interests or Forwardness _____

___ Nightmares _____

___ Crying _____

___ Anger/Temper Tantrums _____

___ Hitting Others _____

___ Frustration _____

___ Disappointment _____

___ Jealousy _____

PHYSICAL INFORMATION

Does this individual:

___ Tire Easily _____

___ Have Difficulty with Coordination _____

___ Require Crutches, Braces, Wheelchair, etc. _____

If so, can they be removed? _____ When? _____

___ Have Seizures _____

If so, describe _____ Frequency _____

___ Have Hearing Loss _____ Wear a Hearing Aid _____

___ Have Visual Loss _____ Wear Glasses _____

___ Have Difficulty Communicating and Making Self Understood _____

EXCESSIVE BEHAVIOR

Are there things this individual does in excess? Examples: eat, drink, sleep, physical activity, etc.

Excessive Fears? _____

Compulsive Behavior? _____

DISCIPLINE

What forms of discipline do you use with this individual, and does he or she respond to it favorably?

PERSONAL HYGIENE INFORMATION

Does this individual have difficulty with:

____ Going to the Toilet Alone _____

____ Remembering to Go to the Toilet _____

____ Menstruation _____

____ Does This Individual Require Diapers _____

MEDICATIONS

We will NOT administer any medications, but the following information is needed in case of an emergency.

Is this individual on medication? YES _____ NO _____ If yes, please indicate ALL medications by name and frequency:

Medicine

Frequency

Reason For Taking

ALLERGIES

Is this individual allergic to any of the following (please circle and explain):

None

Food

Trees

Weeds

Medications

Insect Bites

Other

How does this individual view his/her own intellectual and/or physical limitations? Is he/she accepting of this? Is he/she sensitive about this?

Please add any other information you feel would benefit us in working with this individual.