CONSEIL CRI DE LA SANTÉ ET DES SERVICES SOCIAUX DE LA BAIE JAMES
CREE BOARD OF HEALTH AND SOCIAL SERVICES OF JAMES BAY

Disability Programs
Specialized Services

CASE MANAGEMENT: DISABILITY CLIENT PROFILE - CHILD

(Birth to 21 years)

This form should be completed by the case manager and the family together (in-person or by phone)
For any question - if you don't know what to write, that's okay, move on to the next question.

*****How do you see us working together today?/What are your goals for today?/What do you want to begin to explore together today?**

____
____
____

Support

How are you feeling about supporting your child?
Make a mark between 1 and 5 to indicate their response.

1--------------------- • ------------------------------ • --------------------------------- • -----------------------5
I'm doing **great** — I'm really **struggling**

1--------------------- • ------------------------------ • --------------------------------- • -----------------------5
I'm **well rested** — I'm **exhausted**

1--------------------- • ------------------------------ • --------------------------------- • -----------------------5
Sometimes I need a break from my child — I need a break from my child **right now**

1--------------------- • ------------------------------ • --------------------------------- • -----------------------5
I'm **not worried** about my child's mental health — I'm **really worried** about my child's mental health

Who helps you take care of your child? **Circle any that apply**

(Aunts) (Uncles) (Older Children) (Grandparents) (Someone Else)____________?

Thinking about the help that you are getting with your child, what do you find the most helpful?

____
____

Is there someone who you can share your concerns about your child with? Yes☐ No☐

Do you need anything else to support your child? If yes – please explain.

____
____

Daycare

Does or did your child attend daycare? Yes☐ No ☐

If yes, how is daycare going? ☐ Okay ☐ Good ☐ Difficult

Are you getting calls or messages from the educators or director? Yes☐ No ☐

If yes, about what?

____ ___________________

____

____

School

Does or did your child attend school? Yes☐ No ☐

How has school been going for your child? ☐ Okay ☐ Good ☐ Difficult

Are you getting calls from the teachers or principal with concerns about your child? Yes☐ No ☐

If yes, what did they call you about:

____

____

Daily Life

Can you tell me about your routine on a regular weekday for your child and your family? Start from the moment that they wake up and tell me what a regular day is like up until they are asleep in their bed?

AM	**PM**
•	•

Can you tell me about your routine on a regular weekend for your child and your family? Start from the moment that they wake up and tell me what a regular day is like up until they are asleep in their bed?

AM	**PM**
•	•

Are there any chores/tasks (e.g., using the toilet, washing, getting dressed, etc.) during the day that your child needs help with? **Which ones?**

____
____

What is bedtime like?
Is it easy to for your child to fall asleep? Yes☐ No ☐
Do they wake up during the night? Yes☐ No ☐
Are there any challenges around bedtime?

____

What are mealtimes like?
Is your child a picky eater? Yes ☐ No ☐
Do they eat and drink enough during the day? Yes ☐ No ☐
Are there any challenges around mealtimes?

____

<u>Leisure/Cultural/Traditional/Social</u> (*These are activities that the child does as a hobby.)*

What does your child like to do for fun?

____
____

Does your child need help to do the things they like to do? Yes ☐ No ☐
If yes, what does that help look like?

____
____

Does your child like to do things with other people?
Circle all that apply. (Children) (Youths) (Adults).
If yes, with who?
____

What does your child **NOT** like to do?
____
____

What happens if you try to get them to do things they don't like to do?
____
____

When your child doesn't want to do something, how do you encourage them to try?
____
Does this work? Yes ☐ No ☐

Are there any other challenges around the child's daily activities that you would like to share?
____
____

Moving Around (Mobility)

Write an X or a checkmark for each that apply
Does your child:

	Yes
Sit	
Crawl	
Stand	
Walk	
Climb up stairs	
Climb down stairs	

Does your child use any equipment to move around?

	Yes
Wheelchair	
Walker	
Standing frame	
Leg braces	
Lift	
Adapted stroller	
Adapted bike	
Other: ______________________________	

Are there any challenges your child experiences moving around at home or in the community? What are they?
____

Physical/Health

SIGHT:

Has your child's vision (eyes) ever been tested? Yes ☐ No ☐
When was your child's last vision test (eye check-up)? ______________________________________
Does your child have eyeglasses? Yes ☐ No ☐
Do they wear them regularly? Yes ☐ No ☐

HEARING:

Has your child's hearing ever been tested? Yes ☐ No ☐
When was your child's last hearing test? _________________________________
Does your child have an assistive-hearing device? Yes ☐ No ☐
Do they use it regularly? Yes ☐ No ☐

DENTAL

Have your child's teeth ever been looked at by a dentist? Yes ☐ No ☐
If yes, when was your child's last dental appointment? _________________________________
Was their appointment in the community or outside of the community? **Circle one** (Inside) (Outside)

Developmental

COMMUNICATION:

What language(s) does your child understand? Cree ☐ French ☐ English ☐ Other___________________
What language(s) does your child speak? Cree ☐ French ☐ English ☐ Other ________________________
How do they share their wants/needs with others?

Words ☐ Noises ☐ Pointing ☐ Pictures ☐ or Something else?_____________________________

Do people other than you (and your family) understand what your child wants/needs? ☐ Yes ☐ No ☐

SENSORY:

Have you ever noticed that your child experiences certain senses very strongly? Yes ☐ No ☐
Which ones? Circle the ones where the answer is "yes". **Leave it blank if the answer is "no" or "I don't know".**

(Touch) (Taste) (Sounds) (Smells) (Movement)

If yes, what does the child do when they are experiencing these senses (e.g., Putting things in their mouth, go into a daze, screaming, covering their ears, run away, flapping their hands, etc.)?
____
____
If yes, do these behaviors worry you at all? Yes ☐ No ☐

Which ones?____

Medical

Are you aware of any diagnoses that your child has been given? Please write a checkmark or an X next to any diagnosis that you remember and the year it was given. **Leave it blank if the answer is "no" or "I don't know".**

Known Diagnosis	Yes	What Year
ADHD (Attention Deficit Hyperactivity Disorder)		
Allergies		
Autism		
Cerebral Palsy		
Developmental Delays (please circle which one(s): fine motor, gross motor, language)		
Diabetes		
Down Syndrome		
FASD (Fetal Alcohol Spectrum Disorder)		
Global Developmental Delay		
Language Disorder		
Learning Disability		
Spina Bifida		

Is there anything else that you want to share that is not on this list?

____

____

Is your child receiving any services or have they received services before?

Service	Yes	What Year
Special Needs Educator (SNE)		
Psycho-Educator		
Art/Music Therapy		
Occupational Therapy		
Psychiatrist		
Psychologist		
School Tutor		
Social Worker		
Community Worker		
Speech-Language Pathology		
Cultural ___________________________		
Other_____________________________		
Other______________________________		

Were these services helpful for your child and your family? If yes, how were they helpful?

____
____

MEDICATION:
Is your child taking medication? (Has the doctor ever given you any pills, liquids, or patches for your child to take?) Yes ☐ No ☐
If yes, do you remember which one(s)? (Fill in chart)

Name of Medicine	When does your child take the medication?	What does this medication help with?

Is it easy for your child to take their medication regularly? Yes ☐ No ☐
If no, what challenges are you facing?____

Do you want more information from the doctor or nurse on your child's medication? Yes ☐ No ☐

Conclusion

At the beginning we identified some goals that were important to you (**refer to *** question at the very beginning of this form**). Are these still the priorities for you? Would you like to add or remove anything?
____
____
____

Is there anything that you wish we talked about today but we didn't?
____
____

<u>For Office Use only: General Information</u>:

Please fill this out as best as you can BEFORE the meeting starts.

File #__________
Name of client:__________________
Date of Birth: _______________ Birth sex: Male ☐ Female ☐ Prefer not to say ☐
Phone Number: __________________
Community: ___________________________
Name of Parent: _______________________ Phone Number: ________________
Name of Parent:________________________ Phone Number: ________________
Name of Caregiver(s): ____
Where is the child living (address)? ____

Name of staff filling in form: ____
Job title of staff filling form:
____
Date form was filled out: ________________________
Family member/caregiver present: Yes☐ No☐
If yes, who?
Name __________________________ Relationship to youth ___________________________________