



DEFINITION OF THE SITUATION

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Child's Name ----- Age ----- Date of Birth -----
Address ----- Contact No. -----
Father's Job ----- Father's Contact No.-----Age -----
Mother's Job ----- Mother's Contact No.----- Age -----
Information Provider's Name----- Connection to Child-----

Is your Child Exposed to violence?

What are your child's issues?

- Behaviorism
- Psychological
- Academic Achievement
- Disability

What kind of violence is your child exposed to?

- Psychological Abuse – Source -----
- Physical Abuse – Source -----
- Sexual Assault – Source-----
- Sexual Harassment – Source-----
- Emotional Violence – Source-----

Do you want Manama Center for Human Rights to follow up on your child's violent?

- Yes No

I hereby confirm that all the data and information in this form are valid

Date----- Signature-----

Language Development

Is your Child:

- Repeats sounds, words and sentences?
- Understands what you say?
- Refers to common objects when asked (Cup, Ball, Shoes)
- Performs simple directions (close the door, bring the key)
- Correctly answers question with (yes, no)
- Can socialized with others
- Pronounce words correctly

Your Child currently communicates by:

- Sentences consisting of 2 to 4 words
- Body language and signs
- Sometimes Sentences are longer than 4 words but not in all cases
- Phonetic and Sounds
- Uses words and connections that makes sense
- using clear words

Indicate your child's behavioral aspects:

- Impulsive
- Aggressive
- eye contact
- Distracted
- Nervous
- Stubborn
- Puts things in his mouth
- does not listen
- Dependent
- isolates
- moody
- Bad behavior
- Does not communicate with others
- Excessive movement
- Bored
- Bad words

Medical History

- Does your child have any of the following problems?

- | | | |
|---|---|---|
| <input type="checkbox"/> Problems in Chewing | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Problems with perception | <input type="checkbox"/> Problems with vision | <input type="checkbox"/> Spasm attacks |
| <input type="checkbox"/> Mobility Problems | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Problems swallowing | <input type="checkbox"/> Blocked ears | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Inflammation in the ears | | |

- Other health Problems -----

- Does your child regularly see a doctor? Yes No

If yes, mention the problem why -----

- Please write any medical prescriptions that your child receives-----

- Has your child had any operations? Yes No

Evolutionary History

- Write the approximate age of your child when you notice the following:

Combining syllables together----- Sitting -----

Their First Words----- Walking -----

Pronouncing simple sentences -----Antagonism-----

learning about things and people -----Putty training -----

- Are there times when the child's speech is better than other days?

Yes No

If yes, please specify-----

- Does the problem affect the child's relationship with family members or others?

Yes No

- Is the Child aware of the problem?

Yes No

If yes, how do they feel towards the problem? -----

What steps have been taken to improve the child's problem? -----

Pregnancy and Childbirth Period

- Was there anything abnormal during the pregnancy and childbirth?

Yes No

If yes, please specify -----

- What was the duration of the pregnancy? -----

- The Mother's Age when pregnant? -----

- Caesarean Normal Delivery Type

- Did the mother suffer from psychological stress or illness during the pregnancy?

Yes No

If yes, please specify-----

- Did the child stay in hospital after the delivery?

Yes No

If yes, why? How long? -----

Date of Problem

- Describe the child's problem

- When did the problem first appear? How did the family deal with it?

- What is the cause of the problem, in your opinion?

- Has the problem improved since its first appearance?

Yes No

If yes, For the better For the worse

How-----

Relationship to the child-----

Are there similar problems in the family? -----

- Has your child received any kind of assessment, examination or diagnosis?

Yes No

If yes, where is the diagnosis has been done? When? -----

What was the result? -----

- Has your child received any type of medication or remedial sessions?

Yes No

If yes, please specify -----
