PROBATE COURT OF FRANKLIN COUNTY, OHIO
JEFFREY D. MACKEY, JUDGE

IN THE MATTER OF _____

CASE NO. _____

CASE HISTORY OF DEVELOPMENTAL DISABILITY

This form must accompany Medical Certificate of State Institution. To be completed by examining physician, deputy or other person designated by the court.

1. Name _____ Birthdate _____ Social Security No. _____

2. Sex _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Religion _____

3. Place of Residence _____

   _____ County of legal residence _____

4. Person designated next of kin: Name _____

   Address _____

   Phone No. _____ Relationship _____

5. Name and address of family doctor _____

   _____

6. Name and address of any other doctors, clinics, or hospitals having had contact with this case and the nature of that contact _____

   _____

   _____

   _____

7. Reason for commitment at this time _____

   _____

   _____

   _____

   _____

   _____

CASE NO. _____

8. Father's name and address _____

_____

9. Mother's name and address _____

_____

10. List any blood relatives who have a history of convulsions, developmental disability or admission to a public or private hospital for mental illness or developmental disability, giving place and date: _____

_____

_____

11. Did mother have any illness during pregnancy? Yes ☐ No ☐ If yes, describe. _____

_____

12. Was baby full term? Yes ☐ No ☐ Birth weight _____ Oxygen used? Yes ☐ No ☐

Describe: _____

_____

13. Was there any difficulty with the birth? Yes ☐ No ☐ Describe fully: _____

_____

14. What and when were the first signs of developmental disability noted? Describe fully: _____

_____

15. At what age did the patient walk? _____ Talk? _____

16. Can patient walk without assistance? _____

17. Is patient toilet trained? Yes ☐ No ☐ Describe: _____

18. At what age was patient toilet trained for urine? _____ Bowels? _____

19. Can patient feed self with spoon? Yes ☐ No ☐ Describe: _____

20. Can patient dress self (work zipper, button clothes, tie shoes)? Describe: _____

_____

21. Has patient had serious accidents or injuries? Yes ☐ No ☐ Describe fully and give age at occurrence: _____

_____

_____

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22. Has patient had serious illnesses or operations? Yes ☐ No ☐ Describe fully and give age of occurrence:

_____

_____

_____

23. Has patient had convulsions, fainting, blackouts or spasms? Yes ☐ No ☐ At what age? _____

Describe fully: _____

_____

24. Is patient presently on medication? Yes ☐ No ☐ List medication and dosage: _____

_____

_____

25. List any drugs, which have caused difficulty (allergy): _____

_____

26. Is there any defect of hearing and vision? Yes ☐ No ☐ Describe: _____

_____

_____

27. Has the patient had the following diseases and immunizations?

Disease	**When patient had disease**	**Dates of Immunizations**
Measles		
Mumps		
Smallpox		
Diphtheria		
Whooping Cough		
Tetanus		
Polio		

28. Check following behavior traits, if present:

Fire Setting ☐ Aggressive ☐ Sexual Misconduct ☐ Stealing ☐ Combative ☐ Withdrawn ☐

CASE NO. _____

29. Has patient ever been to school? Yes ☐ No ☐ If yes, name and location of school _____

_____

What grades? _____ Special education classes? _____

30. If excluded, give dates and reasons: _____

_____

31. Has patient ever been tested psychologically? Yes ☐ No ☐ Give dates: _____

Where tested? _____ I.Q. scores, if known: _____

32. Has patient ever worked for pay? Yes ☐ No ☐ Describe: _____

_____

33. Has patient ever lived in place other than his/her own home? Yes ☐ No ☐ Please give dates, names and addresses: _____

34. Has patient been told why he/she is being brought to an institution? Yes ☐ No ☐

The above information furnished by _____

Address _____

Relationship to patient _____

This information is true to the best of my knowledge.

_____ _____

Date Signature

Reset Form