Berks County Intermediate Unit
an educational service agency

For Office Use
Received: _____ Team: _____

CAREGIVER INSIGHTS

Dear Parent/Guardian: You know your child best. Please share what you know with us. This information will help us complete a thorough evaluation of your child's strengths and needs. If you prefer to share information verbally, please call 610-987-8543 to request a caregiver insights interview.

Child name: _____ Birth date: _____ Today's date: _____
Form completed by: _____ Relationship to child: _____
Phone number: _____ Email: _____
Address: _____
Does your child receive Medical Assistance? ☐ Yes ☐ No If yes, please list MA #: _____

FAMILY INFORMATION: TYPICAL DAY

Describe your child's typical day (ex: mealtimes, sleep times, activities)

Do you have concerns about your child in the following areas?		
Communication *Ex: speaking, understanding*	☐ Yes ☐ No	Comments:
Problem-Solving/Pre-academics *Ex: attention, memory, concepts*	☐ Yes ☐ No	
Social Skills *Ex: play skills, peer interaction*	☐ Yes ☐ No	
Behavior *Ex: defiance, aggression*	☐ Yes ☐ No	
Self-Help Skills *Ex: feeding, dressing, toileting*	☐ Yes ☐ No	
Fine Motor Skills *Ex: small muscles (picking up items, drawing)*	☐ Yes ☐ No	
Gross Motor Skills *Ex: big muscles (walking, running, jumping)*	☐ Yes ☐ No	

What are your primary concerns for your child?

What are your child's strengths or positive characteristics?

FAMILY INFORMATION: RESOURCES

Who lives with the child in the home?		
Name	Relationship	Age

Language Survey

What languages are spoken in your home? _____

What language does your child most frequently hear at home? _____

What language does your child most frequently speak at home? _____

Are there any family issues that could be affecting your child's development?

(ex: recent move, separation/divorce, loss of family member/pet, change in living situation)

☐ Yes ☐ No If yes, please list:

Are there any cultural concerns on the part of your family regarding your child's education?

(ex: religious, language, or cultural preferences)

☐ Yes ☐ No If yes, please list:

Does your child attend child care, preschool, or a playgroup that meets regularly? ☐ Yes ☐ No

Program name: _____ Teacher name: _____

Phone number: _____ Days and times: _____

Address: _____

Outside of immediate family, are there other people or community supports involved in your child's life?

(ex: extended family, friends, religious or community organizations, clubs/sports, library activities)

☐ Yes ☐ No If yes, please list:

HEATH, HEARING, AND VISION

Birth History

Length of pregnancy (in weeks): _____ Birth weight: _____

Describe any unusual circumstances/complications experienced during pregnancy, labor, or delivery, if any:

Family History

Please check all that apply	Relation (*ex. parent, sibling, cousin)*
☐ Speech/language concerns *(ex: speech delay, stutter)*	_____
☐ Developmental delays	_____
☐ Learning difficulties	_____
☐ Attention-deficit/hyperactivity disorder (ADHD)	_____
☐ Autism Spectrum Disorder	_____
☐ Mental health concerns *(ex: depression, anxiety)*	_____
☐ Seizure disorder	_____
☐ Other (please list)	_____

Who is your child's physician?

Doctor's name: _____ Phone number: _____

Address: _____

Date of most recent well visit: _____

Are your child's immunizations up to date?

☐ Yes ☐ No Proof of immunizations will be required for your child to receive services if found eligible.

Has your child been diagnosed with a condition(s)? *(ex: autism, ADHD, apraxia, genetic disorder)*

☐ Yes ☐ No If yes, by whom *(ex: agency/pediatrician/psychologist name)*: _____

Please describe (and provide documentation such as an evaluation report, if available):

Does your child take medication(s)?

☐ Yes ☐ No If yes, please list name, dosage, and reason for taking:

Does your child use adaptive equipment? *(ex: glasses, hearing aid, braces, wheelchair)*

☐ Yes ☐ No If yes, please describe:

Has your child experienced any of the following?

High lead levels	☐ Yes ☐ No	Date of most recent test? _____ What level? _____
Frequent colds	☐ Yes ☐ No	How often? _____
Major illnesses/accidents	☐ Yes ☐ No	Please describe. _____
Seizures	☐ Yes ☐ No	Please describe. _____
Allergies	☐ Yes ☐ No	Please describe. _____
Asthma	☐ Yes ☐ No	

Hearing *(Please share a copy of most recent audiogram, if available)*	
Results of most recent hearing screening:	☐ Pass ☐ Fail
Date of hearing screening: _____	Who conducted the screening? _____
Does your child have frequent ear infections?	☐ Yes ☐ No If yes, how often? _____
Has your child had ear tubes placed?	☐ Yes ☐ No If yes, when were they placed? _____
Is your child prescribed hearing aids?	☐ Yes ☐ No
Are you concerned about your child's hearing?	☐ Yes ☐ No

Vision	
Results of most recent vision screening:	☐ Pass ☐ Fail
Date of vision screening: _____	Who conducted the screening? _____
Is your child prescribed glasses?	☐ Yes ☐ No
Are you concerned about your child's vision?	☐ Yes ☐ No

Feel free to include additional comments here, if needed.

THANK YOU!