**OUR STORY**

|  |
| --- |
| **Names of Family Members and others who live in our home:**  |
| **Role of Each Member in Our Home: (i.e., primary caregiver, nurturer, etc.)** |
| **Names and role of other important people in our life:**  |
| **Medical Information for my child (including birth history, therapies received outside of EI, past and upcoming surgeries/procedure):****Family/Caregiver medical or mental health concerns (including upcoming surgeries):**  |
| **Preferred language or communication method:****Cultural characteristics** *(common traditions, rituals, symbols, boundaries, preferences, communication styles, diets, etc):* **Important cultural events:****What activities does my family enjoy doing together?****Are we still able to do these activities?****How well is my family able function when we go out into the community?** |

| **Typical Activities in** **Our Day \*\*\* The FDA focuses on the family.**  | * **What is my child is doing during this routine?**
* **How independent is my child during this routine?**
* **Who is helping/participating? Share about the child’s social interactions during this routine.**
* **Where does this routine usually take place?**
* **How does my child communicate/follow directions during this routine?**
* **How easy is it to understand my child during this routine?**
* **What does this routine sound like?**
* **What does transition look like from one routine to another?**
 | * **What is enjoyable/satisfactory and works well for my child and for us?**
* **What is difficult/challenging for my child? For us?**
* **What have I/we tried?**
* **What are my concerns with this routine (if any)?**

**\*\*\*\*\*Replace my child and family with for my family. Do this for every column** |
| --- | --- | --- |
| **Sleep Routines*** Waking Up
* Napping
* Bedtime
 |  |
| **Cleaning up/Getting Ready*** Bathing
* Tooth brushing
* Diapering/Toileting
* Dressing
 |  |
| **Mealtime Routines*** Breakfast
* Lunch
* Snacks
* Dinner
 |  |
| **Playing** * Play interactions with adults/children
* Play interests
* Preferred play environments
* Favorite toys, games, activities
 |  |
| **Typical Activities in** **Our Day** | * **What is my child is doing during this routine?**
* **How independent is my child during this routine?**
* **Who is helping/participating?**
* **Where does this routine usually take place?**
* **How does my child communicate/follow directions during this routine?**
 | * **What is enjoyable and works well for my child and for us?**
* **What is difficult for my child? For us?**
* **What have I/we tried?**
* **What are my concerns with this routine (if any)?**
 |
| **Outings/getting around*** Riding in the car seat
* Favorite places to go/things to do
* Errands
* Special Occasions/Activities
 |  |

|  **Additional Information About My Family****My family’s priorities are:****My family’s concerns are:****Areas where improvements would be helpful for my family:****Strengths within my family include:*** **Our family currently uses the following formal services, supports and agencies (**BCMH, WIC, Medicaid, CBDD Family Support Funds, private insurance, healthcare marketplace insurance)
* **Other informal resources that our family uses (church, neighbors)**
* **Other resources that would be helpful:**
* **What would my family like to do that we can no longer do?**
* **If we have an emergency we can call (relatives, friends, agencies, programs, etc)**:
* **Current worries or concerns about my child:**
* **The Ohio Early Intervention Program can help us be successful by:**
 |
| --- |