SOCIAL AND DEVELOPMENTAL HISTORY

Student's Name: _____ □ Male □ Female
First Middle Last

School Attending: _____ Grade: _____ Date of Birth: _____

Parent's Names: _____
Address: _____
_____

Telephone: Home: _____ Work: _____ Cell: _____

Parent email address: _____

Legal Guardian Status (check one)

□ 01 – Biological Parents
□ 02 – Biological Mother
□ 03 – Biological Father
□ 04 – Adoptive Parents
□ 05 – Adoptive Mother
□ 06 – Adoptive Father
□ 08 – Family & Children's Svcs.
□ 09 – Court (specify) _____
□ 10 – Other (specify) _____

Marital Status of Parents (check one)

□ Married □ Single □ Married, living apart
□ Divorced (check custodial status)
□ Joint custody
□ Sole custody (check which parent)
□ Mother □ Father
Does child have visitation with non-custodial parent? □ Yes □ No

□ Other (explain) _____

Father's Occupation: _____ Mother's Occupation: _____

Stepparent's Occupation: _____

List the name and ages of all people currently living at your child's residence:

Name	Relationship to Child	Age and Education Level	Primary Language
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your child's primary language? _____

Are there other languages spoken in the home? □ Yes □ No If so, what language(s): _____

GENERAL:

What are your hopes or vision for your child? _____
_____

What concerns do you have about or for your child? _____
_____

In your opinion, why is your child being referred or evaluation? _____
_____

Briefly describe your child's current difficulties: _____
_____

What would you like to learn from the evaluation? _____
_____

MEDICAL AND DEVELOOPMENTAL HISTORY

Describe any complications, medications, or other concerns experienced during the pregnancy (e.g., diabetes, high blood pressure, toxemia, ect.): _____
_____

Is your child taking the Meds? □ Yes □ No: If no, explain: _____
_____

At the time of birth/delivery:
Was the child full term? □ Yes □ No Duration of pregnancy: _____
Cesarean Section? □ Yes □ No Birth weight: _____

Please describe any complications with the birth, delivery, or after delivery: _____
_____

List any serious illness, injury, hospitalization, surgery, or traumatic event (e.g. diabetes, seizures, head injury, asthma, allergies, etc.): Child's age at time:

_____ _____
_____ _____
_____ _____

Current Medical diagnoses (if any)	Physician's name	Date of diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

***** Please attach any pertinent physician report or diagnostic statement***

List all currently prescribed medications

Medication	Dosage	Prescribing physician and date prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vision Problems? □ Yes □ No Glasses? □ Yes □ No Contacts? □ Yes □ No
Date of last vision exam: _____ Results: _____

Hearing problems: □ Yes □ No Age detected: _____
Tubes in ear: □ Yes □ No Date: _____
Hearing aids: □ Yes □ No
Cochlear implant: □ Yes □ No Date: _____

Date of last hearing exam: _____ Results: _____

Has the child ever been to a counselor, therapist, psychologist or psychiatrist? □ Yes □ No
If yes, please explain: _____
_____

Has your child been evaluated by someone other than the public school? □ Yes □ No
** ***Please attach a copy of the evaluation report***.

Do you have a family history (biological parents, siblings, grandparents, aunts, uncles) of any of the following?

- □ Learning difficulties (reading, spelling, writing, math, organization)
- □ Speech or language difficulties (articulation, stuttering, organizing/recalling words, etc.)
- □ Emotional difficulties (depression, anxiety, mood swings, psychosis, etc.)
- □ Cognitive difficulties (may have been called mental retardation or mental handicap)
- □ Genetic medical conditions
- □ Abuse or domestic violence
- □ Substance abuse (drug or alcohol)

If so, please describe: _____
_____
_____

DEVELOPMENTAL INFORMATION

Age	Age	Age
Sat alone _____	Spoke first word _____	Toilet trained _____
Crawled _____	Put several words together _____	Stayed dry at night _____
Walked alone _____	Spoke in complete sentences _____	

Describe child's early temperament (e.g. sensitive, irritable, active, passive, happy, stubborn, etc.)
_____

Do you have any concerns about your child's development or behavior? □ Yes □ No
If yes, please explain: _____
_____

Are there conditions at home that may be influencing your child's development and/or behavior (e.g., family, Illness, marital issues, etc.)? □ Yes □ No
If yes, please explain: _____
_____

ADAPTIVE BEHAVIOR
Does your child have any difficulty or delay in the following areas (check all that apply)? If so, please describe.

Communication skills

□ Making or producing speech sounds _____
□ Understanding language _____
□ Using language to communicate _____
□ Understanding social communications _____
□ Reading/understanding body language and nonverbal communication _____

Oral motor skills

□ Chewing solid food _____
□ Drinking from a cup _____
□ Drinking through a straw _____
□ Excessive drooling _____
□ Swallowing problems _____
□ Sensitivity to different textures of food/drink _____
□ Sensitivity to different temperatures of food/drink _____

Motor Skills

□ Walking _____
□ Running _____
□ Jumping _____
□ Climbing stairs _____
□ Walking on uneven surfaces _____
□ Balance _____
□ Manipulating small objects with hands _____
□ Using silverware or writing utensils _____
□ Tying shoes, using zippers, buttons. Etc. _____

Independent Living Skills

□ Feeding self _____
□ Dressing self _____
□ Personal hygiene _____
□ Toileting _____
□ Bathing self _____
□ Performing assigned chores _____

Responses to sensory experiences

Does your child display any unusual or atypical behaviors, responses, or sensitivities in any of the following areas?

□ Taste _____
□ Smell _____
□ Movement _____
□ Tactile/touch/texture _____
□ Visual _____
□ Auditory/filtering _____
□ Activity level/weakness _____
□ Other (please describe) _____

Patterns of Emotional Adjustment

Do you consider any of the following to be a problem for your child at this time (check all that apply)?

□ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
□ Talks excessively, interrupts often, doesn't listen
□ Often depressed/irritable mood
□ Low energy/fatigue
□ Shy

□ Often loses things, very disorganized compared to others of his/her age
□ Poor concentration
□ Difficulty initiating task
□ Difficulty completing tasks
□ Difficulty following instructions
□ Engages in impulsive behavior \(acts before thinking)
□ Immature compared to peers
□ Engages in physically dangerous activities
□ Often argumentative with adults
□ Often actively defiant to adult requests and rules
□ Often deliberately does thing to annoy others
□ Blames others for own mistakes
□ Often angry or resentful
□ Somatic complaints of not feeling well
□ Excessive separation difficulties
□ Easily frustrated
□ Lies
□ Steals
□ Feeling of worthlessness or low self-esteem
□ Withdrawn
□ Overly anxious or fearful
□ Sleeping too little/insomnia
□ Sleeping to much
□ Difficulty making decisions
□ Cries easily
□ Temper tantrums
□ Rapid mood changes/mood swings
□ Suicidal thoughts
□ Aggressive towards others: □ Peers □ Adults
□ Poor appetite
□ Overeats
□ Explosive temper with minimal provocation
□ Odd fascinations
□ Unrealistic worry about future events
□ Excessive need for reassurance
□ Substance abuse □ Drug □ Alcohol
□ Other

Please explain any checked items: _____

_____

_____

_____

_____

Unusual or Atypical Behaviors

Does your child display any of the following behaviors (check all that apply)?

□ Preoccupation with specific subjects, topics, or objects that is atypical in intensity or focus
□ Eccentric forms of behavior
□ Lack of awareness or sensitivity to the need or feelings of others
□ Facial expression or emotional responses that are not appropriate to or consistent with the circumstances
□ A need or desire to do things in a very specific way or order, or rituals that must be followed
□ Mannerisms or odd ways of moving his/her body
□ Self injury or physical aggression toward others
□ Difficulty understanding jokes or humor
□ Difficulty adjusting to new surroundings
□ Difficulty adjusting to change in plans or routines
□ Others

Please explain any checked items: _____

_____

_____

_____

SOCIAL SKILL INFORMATION

How does your child get along with adults at home? _____

_____

_____

How does your child get along with brothers and sisters or other children in the home? _____
_____
_____

How does your child get along with peers? _____
_____
_____

Describe your child's friendships: _____
_____
_____

What are your child's favorite activities? _____
_____
_____

What are your child's behavioral and social strengths? _____
_____
_____

What are your child's behavioral and social weaknesses? _____
_____
_____

SCHOOL INFORMATION

List, in order of attendance, the schools your child has attended (for children 7 and younger, include preschools And daycare center attendance)

School/Preschool/Daycare	Dates of attendance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has your child every repeated a grade? □ Yes □ No
If yes, what grade was repeated? _____ What School? _____

Describe your child's strengths at school: _____
_____

What are your child's weaknesses at school? _____
_____
_____
_____
_____
_____

Have there been any major changes in your child's attitude towards school? □ Yes □ No
If yes, please describe: _____
_____

Has your child been involved in any of the following (please check all that apply)?

	Dates:	For How long:
□ Educational services from private entity (e.g., private tutor, Sylvan, Learning Rx, Lindamood Bell, etc.)	_____	_____
□ Therapy services from private entity (e.g., speech, occupational/physical therapy, vision therapy, etc.)	_____	_____
□ Counseling	_____	_____
□ Department of Children's Services	_____	_____
□ Juvenile Court or probation	_____	_____
□ Hospitalization	_____	_____
□ First Steps	_____	_____
□ Jumpstart (ISTEP "Remediation)	_____	_____
□ Summer School	_____	_____
□ Evaluation from private entity (e.g., psychological, academic/educational, mental health, behavioral, etc.)	_____	_____
□ Other Early intervention program	_____	_____

If other, please list: _____

Please explain items checked: _____
_____
_____
_____

** ***Please attach any relevant reports.***

Other information you believe may be relevant in the evaluation of your child: _____
_____
_____
_____
_____
_____
_____
_____
_____

Name of person completing this form: _____