

INITIAL SOCIAL AND DEVELOPMENTAL HISTORY

Child's Name _____ Birthdate _____ Age _____
 School _____ Grade _____ Sex: Male Female
 Home Address _____ Phone _____

Ethnic Background (Circle one): American Indian or Native Alaskan, Asian or Pacific Islander, Hispanic, Black American, White (not Hispanic), Multiracial

Person completing this form: (Circle one): Natural Mother, Natural Father, Foster Parent, Stepmother, Stepfather, Adoptive Parent or Other (Please explain): _____

Date Form Completed _____ Date Form Received by School Psychologist _____

Marital status of parents: _____

If separated or divorced, how old was child at separation _____ at divorce _____

Who has custody of this child? _____ Does the child have contact with the non-custodial parent? _____

How often does the non-custodial parent see this child? (Circle one): At least Weekly, Monthly, Few times each Year, or Never

Is either biological parent deceased? Mother _____ Father _____ If Yes, indicate the year _____

Mother's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Father's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepmother's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepfather's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

List all brothers and sisters, or others living with the family and their relationship to the child.

Name	Age	Sex	Relationship to child	Living in home?	Living outside home?

Describe the child's relationship with siblings or others in home. _____

Has the student been involved in any of the following settings? If yes, indicate the dates: Foster home _____

Group home _____ Correctional Facility _____ Psychiatric Facility _____ Other (specify) _____

Primary language spoken in the home: _____ Other languages spoken in the home: _____

What was the first language learned? _____

If other than English, at what age did your child begin to speak English? _____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any family member has had. When you check an item, list the family member's relationship to the child.

- | | |
|---|---|
| <input type="checkbox"/> Academic Problems _____ | <input type="checkbox"/> Emotional Problem _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Trouble _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Neurological Disease _____ |
| <input type="checkbox"/> Developmental Problems _____ | <input type="checkbox"/> Suicide Attempt _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other Medical Issues _____ |
| <input type="checkbox"/> Drug Problems _____ | |

DEVELOPMENTAL FACTORS

PREGNANCY: Mark if mother had any of the following during pregnancy:

- | | | |
|------------------------|------------------------------------|--|
| _____ Hospitalizations | _____ Diabetes | _____ Infectious Diseases (List) _____ |
| _____ Convulsions | _____ High Fever | _____ Exposure to X-rays or Chemicals |
| _____ German Measles | _____ Medications (specify): _____ | |

IS THERE A PRENATAL HISTORY OF MOTHER USING (indicate which trimester)

- | | | |
|---|---|--|
| Cigarettes 1 st ___ 2 nd ___ 3 rd ___ | Alcohol 1 st ___ 2 nd ___ 3 rd ___ | Recreational Drugs 1 st ___ 2 nd ___ 3 rd ___ |
| When did the Mother have physician care during pregnancy? 1 st ___ 2 nd ___ 3 rd ___ | Prescription or other Drugs 1 st ___ 2 nd ___ 3 rd ___ | |

BIRTH FACTORS:

- Length of pregnancy: _____ Weight at birth: _____ Was a caesarean (C-section) performed? _____
- Prolonged, difficult or forced labor? _____ Birth defects or complications: _____
- Were there any special problems within the first month? _____

EARLY DEVELOPMENT: At what age did the child do the following:

- | | | |
|-----------------|-------------------------|--|
| Sit alone _____ | Speak first words _____ | Speak in Sentences (2 – 3 words) _____ |
| Crawl _____ | Walk alone _____ | Have Bladder and Bowel Control _____ |

Did the doctor indicate any developmental problems during the child's first three years of life? Yes _____ No _____ If Yes, please explain. _____

SPECIAL FACTORS

VISION:

- _____ No apparent problem
- _____ Vision Examination
date _____ by whom _____
- _____ Wears glasses
- _____ Wears contacts
- _____ Had surgery (specify: _____ age _____)

HEARING:

- _____ No apparent problem
- _____ Hearing Examination
date _____ by whom _____
- _____ Had surgery (specify _____ age _____)
- _____ Ear infections/frequency _____
- _____ Hearing loss/Age of loss _____

GROSS AND FINE MOTOR:

- _____ No apparent problem
- _____ OT or PT Examination
date _____ by whom _____
- _____ Walking, jumping, running problems -
- _____ Cutting, writing, coloring printing problems
- _____ Other (specify _____)

COMMUNICATION:

- _____ No apparent problem
- _____ Speech and Language Examination
date _____ by whom _____
- _____ Problems expressing thoughts
- _____ Problems pronouncing words
- _____ Other (specify _____)

SOCIAL:

How does your child interact with other children? (list any: fights, play groups, friends, trouble, etc.) _____

How does your child get along with adults? _____

Have you noticed any unusual social interactions? Yes _____ No _____ If Yes, please explain: _____

SCHOOL HISTORY

<u>Preschool/Grade Level</u>	<u>Name of School</u>	<u>Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been absent from school a lot? Yes _____ No _____ If Yes, please explain: _____

SCHOOL INTERVENTIONS

MARK INTERVENTIONS THE CHILD HAS RECEIVED:	YES	NO	GRADES	COMMENTS
Repeated Grade				
Reading Assistance				
Remediation				
Speech/Language Services				
Counseling or Social Services				
Suspension or Expulsion				
Summer School				
Other (specify)				

AGENCY SERVICES

LIST THE AGENCIES THAT HAVE PROVIDED SERVICES FOR THE CHILD:	DATES	REASON (Provide as much detail as possible; use a separate page if necessary)
Private Tutoring		
Private Counselor or Therapist (specify)		
Community Service Agency (specify)		
Mental Health Agency		
Department of Children and Families		
Court System		
Day Treatment Program (specify)		
Inpatient Psychiatric Hospital (specify)		

What do you think your child needs to do that he/she is not doing now and why? _____

Do you have any other questions or concerns? _____

Any other information which would help us understand your child? _____