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 ◻ 04 – Adoptive Parents ◻ 08 – Family & Children's Svcs.
◻ 02 – Biological Mother ◻ 05 – Adoptive Mother ◻ 09 – Court (specify) _________
◻ 03 – Biological Father ◻ 06 – Adoptive Father ◻ 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): ________________

White: AWSSC Yellow: School Pink: Parent/Guardian

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 DEVELOPMENTAL 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:

List any serious illness, injury, hospitalization, surgery, or traumatic event	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: ______________________ Date: ____________