SOCIAL AND DEVELOPMENTAL HISTORY

Student's Name: _____ Gender: ☐M ☐F

Current School: _____ Grade: ____ Date of Birth: ___/____/_____

Parent's Names: _____

Address: _____ Email: _____

_____

Telephone: Home: (_____) _____ Cell: (_____) _____

Legal Guardian Status (check at least one)

☐ Biological Parents ☐ Adoptive Parents ☐ Family/Children Services

☐ Biological Mother ☐ Adoptive Mother ☐ Court (Specify) _____

☐ Biological Father ☐ Adoptive Father ☐ Other (Specify) _____

Marital Status of Parents (check one)

☐ Married ☐ Single ☐ Married, living apart

☐ Divorced (check custody status)

☐ Joint Custody ☐ Sole Custody (Mother or Father- circle one)

Does child have visitation with non-custodial parent? ☐ Yes ☐ No

List the names 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 INFORMATION

Briefly describe your child's strengths:

In your opinion, why is your child being referred for evaluation?

MEDICAL HISTORY

Pregnancy:

Please describe any complications, medications taken, or other concerns experienced during pregnancy (e.g., high blood pressure, toxemia, gestational diabetes, etc.)

_____

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:

Current Medical Status:

Has the child had any serious injuries, illnesses, hospitalizations, surgeries, or traumatic events?

Event	Child's age at the time?
_____	_____
_____	_____
_____	_____

Current Medical Diagnosis (if any)	**Physician's Name**	**Date**
_____	_____	_____
_____	_____	_____

Current Medications

Medication	Dosage	Prescribing Physician/Date Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vision and Hearing:

Date of last vision exam: _____ Results: _____

Vision problems: ☐ YES ☐ NO Glasses? ☐ YES ☐ NO Contacts? ☐ YES ☐ NO

Date of last hearing exam: _____ Results: _____

Hearing problems? ☐ YES ☐ NO Age Detected: _____

Hearing aids? ☐ YES ☐ NO Cochlear Implant? ☐ YES ☐ NO Date: _____

Tubes in Ears? ☐ YES ☐ NO Date: _____

Mental Health:

Has the child ever been to a counselor, therapist, psychologist or psychiatrist?

☐ YES ☐ NO If yes, please explain: _____

_____

Outside Evaluations:

Has your child been evaluated outside of the public-school environment? ☐ YES ☐ NO

If yes, by whom? _____

*******Please attach a copy of the evaluation report.

Family History:

Do you have a family history (biological parents, siblings, grandparents, aunts, uncles, cousins) of any of the following? Check all that apply:

☐ Learning difficulties (reading, spelling, writing, math, organization)

☐ Speech or Language difficulties (articulation, stuttering, trouble recalling words, etc.)

☐ Emotional difficulties (depression, anxiety, mood swings, psychosis, etc.)

☐ Cognitive difficulties (delays in reasoning or global learning)

☐ Genetic medical conditions

☐ Abuse or domestic violence (this includes any abuse or violence the child has experienced as well as any the child has witnessed or is aware of within the home/family)

☐ Substance abuse (drug or alcohol)

Please describe:

DEVELOPMENTAL INFORMATION:

Age	**Age**	**Age**
Sat alone: _____	Spoke 1st word: _____	Toilet Trained: _____
Crawled: _____	Put several words together: _____	Dry at night: _____
Walked alone: _____	Spoke in complete sentences: _____	

Please describe your child's early temperament.

What concerns (if any) do you have regarding your child's development or behavior?

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?

Please check all that apply and describe on the space provided.

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? This may appear as though the child is experiencing a sensation or feeling to a degree that doesn't match the event- or behaves in a way that seems "over the top" given the context of the situation.

☐ Taste _____

☐ Smell _____

☐ Movement (e.g.- walking or moving in a clumsy manner). _____

☐ Tactile (touch/texture) (agitated or stimulated by certain fabrics or surfaces) _____

☐ Visual _____

☐ Auditory/ filtering (e.g.- may be overwhelmed by sounds and cover their ears, or may need to have music or background sound on at all times) _____

☐ Activity level/weakness (e.g.- a child who seems overly active or severely tired and weak in a manner that does not fit their age, recent activity level or recent amount of sleep) _____

☐ Other (please describe) _____

Patterns of Emotional Adjustment:

Do you consider any of the following to be a problem for child at this time?

Please check all that apply:

Activity/Attention:

☐ Fidgets, is easily distracted, has a hard time staying seated, has a hard time waiting for his/her turn

☐ Talks excessively, interrupts often, doesn't listen

☐ Often loses things, very disorganized compared to others of his/ her age

☐ Poor concentration ☐ Difficulty following instructions

☐ Difficulty initiating or completing tasks (circle one or both)

Emotional:

☐ Often depressed, irritable mood ☐ Low energy, fatigue ☐ Shy

☐ Excessive separation difficulties ☐ Easily frustrated ☐ Overly anxious or fearful

☐ Feeling of worthlessness/low self-esteem ☐ Withdrawn ☐ Cries easily

☐ Sleeping too little ☐ Sleeping too much ☐ Excessive need for reassurance

☐ Difficulty making decisions ☐ Temper tantrums ☐ Rapid mood changes

☐ Suicidal thoughts ☐Unrealistic worry about future events ☐ Poor appetite ☐ Overeats

Behavioral:

☐ 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 things to annoy others ☐ Aggressive towards others (Peers / Adults)

☐ Lies ☐ Steals ☐ Substance abuse (Drug / Alcohol)

☐ Explosive temper with minimal provocation

Please explain any checked items

Unusual or Atypical Behaviors:

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

☐ Preoccupation with specific subjects, topics or objects that is atypical in intensity of focus

☐ Eccentric forms of behavior (sometimes referred to as quirky, odd, free-spirited; a person who exhibits eccentric behavior doesn't seem to be concerned with what others are doing, wearing, saying, etc.)

☐ Lack of awareness or sensitivity to the needs or feeling of others

☐ Facial expression or emotional responses that are not appropriate 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

☐ Odd mannerisms or ways of moving his/her body (examples: repetitive foot tapping, rocking, swaying- can be purposeful or unconscious)

☐ Self-injury

☐ Difficulty understanding jokes or humor

☐ Difficulty adjusting to new surroundings

☐ Difficulty adjusting to change in plans or routine

☐ Other

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? _____

_____

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/or daycare center attendance)

School /Preschool/ Daycare	Dates of Attendance
_____	_____
_____	_____
_____	_____

Has your child ever repeated a grade? ☐ YES ☐ NO If yes, what grade? _____

Describe your child's strengths at school: _____

_____

What are your child's weaknesses at school? _____

_____

Has your child been involved in any of the following? Please check all that apply

Service	Dates/Duration
☐ Educational services from a private entity (e.g. private tutor, Sylvan, Learning Rx, etc.)	_____
☐ Therapy services from a private entity	_____
☐ Juvenile Court or Probation	_____
☐ Hospitalization	_____
☐ First Steps	_____
☐ Jumpstart (ISTEP Remediation program)	_____
☐ Summer School	_____
☐ Other Early Intervention Program	_____

If other, please list: _____

Please explain items checked:

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

Name of person completing this form: _____ Date: ____/____/_____