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**Preschool Social and Developmental History**

Date:School:

ID#: Grade:

*The following information is considered confidential. Please answer all questions as well as you can.*

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| **Identifying Information** | |
| Child’s name: |  |
| Date or birth and current age: | DOB: Age: |
| Gender and race: | Gender: Race: |
| Person completing form: | Name: Do you have legal custody? Yes No |
| **Family Information** | |
| Home address: | Street address: Apt/lot #:  City: State: Zip code:  County: |
| Phone number(s) and email address: | Home: Cell:  Work: Email address: |
| **Biological Parents or Guardian Information** | |
| Parent/Guardian  Female name:  Relationship:  Biological Mother  Step-Mother  Adoptive Mother  Grandmother  Other relative  Unrelated  Male name:  Relationship:  Biological Father  Step-Father  Adoptive Father  Grandfather  Other relative  Unrelated | Age: Education: Occupation:  Work title: Employer:  Lives in the home? Yes No  If not biological mother:  Age: Education: Occupation:  Work title: Employer:  Age: Education: Occupation:  Work title: Employer:  Lives in the home? Yes No  If not biological father:  Age: Education: Occupation:  Work title: Employer: |
| The child is: | Natural  Adopted  Been in foster care  Other |
| The child’s parents are: | Married  Divorced  Separated  Never married  If parents are divorced, does the child see the non-custodial parent? Yes \_\_\_\_ No \_\_\_\_\_  If yes, how often? |
| Please list all people living in household. | Name: Age: Relationship to child:  Name: Age: Relationship to child:  Name: Age: Relationship to child:  Name: Age: Relationship to child:  Name: Age: Relationship to child: |
| Primary Language | Language primarily spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other languages spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there a history of learning and/or behavioral problems in the family? Yes or No  List family members and describe. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are there any significant stressors or pressures on the family that could be influencing your child’s behavior? If yes, please explain. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason for referral: Please list any concerns with your child’s development or behavior: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Pregnancy and Birth History** | |
| Mother’s age for this pregnancy and number of this pregnancy. | Age: This pregnancy was:  1st  2nd  3rd  4th  5th |
| Did the child’s mother have any health problems during her pregnancy? Explain if yes. | During pregnancy;  Was mother on medication?  No  Yes:  Did mother smoke cigarettes?  No  Yes:  Did mother consume alcoholic beverages?  No  Yes:  Did mother or father use drugs?  No  Yes:  If you answered Yes to any of the above questions, please explain: |
| The baby was born: | Full-term  Premature: weeks early  Late  Birth weight: lbs. oz. |
| Did the baby breathe on his/her own right away? | Yes  No |
| Were any delivery complications or birth defects noted? Explain if yes. | No  Yes: |
| How soon after birth was the  baby discharged from the hospital? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any problems in the first year of life? Explain if yes. | No  Yes: |
| Did the baby have to return to the hospital during his/her first year of life? Explain if yes. | No Yes: |
| **Developmental History** | |
| **Motor Skills** |  |
| At what age did the child: | Sit up: Crawl: Walk: |
| Was the child slow to develop motor skills or awkward in comparison to his/her siblings? | Large motor skills (i.e. walking, riding a bike, etc.)  Yes  No  Small motor skills (i.e. using hands, drawing/cutting/writing, etc.)?  No  Yes:  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Handedness: | Right  Left  Both |
| Has the child ever had occupational therapy (OT) or physical therapy (PT)? Explain if yes. | No  Yes: |
| **Language Skills** |  |
| At what age did the child: | Speak first word: Put 2-3 words together: |
| Any history of poor sucking, problems chewing, or late drooling? Explain if yes. | No  Yes: |
| Any history of speech delays or problems (e.g., difficult to understand, stuttering, speech therapy)? Explain if yes. | No  Yes: |
| **Toileting** |  |
| When was the child toilet trained? | For urination: For bowel movements: |
| Any problems with bed wetting, daytime urine accidents, or soiling? Explain if yes. | No  Yes: |
| **Temperament & Social Development** |  |
| As a baby, was he/she easy to comfort or soothe? | Yes  No |
| Did the baby have colic? | Yes  No |
| Any trouble getting along with other children his/her age? | No  Yes: |
| The child gets along best with (check all that apply): | Same age  Younger  Older  Adults |
| Which of the following best describes the child in social interactions? | Does not hesitate to join in play with a group of children.  Is sometimes hesitant to join in playing with other children, but does so when encouraged.  Hardly ever plays with other children, but instead prefers to play by him/herself.  Only interacts with family members.  Does not typically seek out social interactions at all. |
| **Sensory Processing** | Does your child have difficulties with any of the following?  Grinds Teeth?  No  Yes Mouths clothes/inedible objects?  No  Yes  Avoids eye contact?  No  Yes Negative reaction to being touched?  No  Yes  Unusual reaction to pain? No  Yes Negative reaction to sounds?  No  Yes    Seeks or avoids odors?  No  Yes Extremely limited food preferences?  No  Yes  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Child/Family Medical History** | |
| Date of last physical exam: | Less than 6 months ago  6 – 12 months ago  1 – 2 yrs ago  More than 2 yrs ago |
| Please note any medical diagnoses your child has received: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Child’s Doctor: |  |
| Any problems with vision or hearing? Explain if yes. | No  Yes: |
| Has the child ever had problems with recurrent ear infections?  Has the child had surgery to place tubes in ears? Give details if yes. | No  Yes  No  Yes: |
| Has the child had any serious illness or injuries? | None List incidents with dates: |
| Describe any head injuries (e.g., date, what happened, changes in behavior after the injury). |  |
| List any hospitalizations or surgeries | None List hospitalizations with dates: |
| Has the child ever had:  (check all that apply) | Seizures or epilepsy  Tics/twitching  Lead poisoning  Loss of consciousness  Exposures to toxins  Asthma  Allergies |
| What medications (if any) have been used to address these concerns in the past? | Medication: Dosage: How often:  Medication: Dosage: How often:  Medication: Dosage: How often: |
| Current medications, dosage, and reason: | Medication: Dosage: How often:  Reason:  Medication: Dosage: How often:  Reason:  Medication: Dosage: How often:  Reason: |
| Has your child ever had contact with a psychiatrist, psychologist, clinic or private agency? Explain if yes.  Has your child ever had an evaluation? | No  Yes:  Yes  No Does the school have a copy of the evaluation:  Yes  No |
| **Consulting Professionals & Other Professionals** | |
| Please list all others involved in the child’s care, including First Steps therapists, psychologists, DCS case workers, or physicians: | Name/Profession: Nature of their involvement: |
| Check all services that the child has received: | Agency Dates of Service  Newborn Intensive Care Unit (NICU) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Steps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occupational Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physical Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Child’s Strengths/Weaknesses** | |
| Please use this space to note the child’s strengths and weaknesses: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please use this space to note any additional comments: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Current Preschool Information** | |
| Name of preschool attending: |  |
| Child attends school: | Full time  Part time  Number of days per week:  What time of day: |