****

**Preschool Social and Developmental History**

Date:School:

ID#: Grade:

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

|  |
| --- |
| **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/GuardianFemale name:Relationship:[ ]  Biological Mother[ ]  Step-Mother[ ]  Adoptive Mother[ ]  Grandmother[ ]  Other relative[ ]  UnrelatedMale name:Relationship:[ ]  Biological Father[ ]  Step-Father[ ]  Adoptive Father[ ]  Grandfather[ ]  Other relative[ ]  Unrelated | Age: Education: Occupation: Work title: Employer: Lives in the home? Yes NoIf not biological mother: Age: Education: Occupation: Work title: Employer: Age: Education: Occupation: Work title: Employer: Lives in the home? Yes NoIf 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 marriedIf 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 NoList 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 [ ]  LateBirth 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 [ ]  NoSmall 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 [ ]  YesUnusual 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 ServiceNewborn 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 timeNumber of days per week: What time of day: |