**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: | :       Age:  |
| Gender and race: | Gender:  Race:  |
| Person completing form: | Name: Do you have legal custody?  |
| **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? If not biological mother:Age:  Education:  Occupation: Work title:  Employer: Age:  Education:  Occupation: Work title:  Employer: Lives in the home? If not biological father: Age: Enter text Education:       Occupation:      Work title:  Employer:  |
| The child is:  |  [ ]  Natural [ ]  Adopted [ ]  Other |
| The child’ parents are: |  [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Never married |
| Please list all siblings, including full, half and step-siblings. | Name:  Age:  Living with child? Name:  Age:  Living with child?  Name:  Age:  Living with child? Name:  Age:  Living with child?  Name:  Age:  Living with child?  |
| Please list anyone else living in the home and relationship to the child. | Name:       Relationship:      Name:       Relationship:      Name:       Relationship:       |
| Are there any significant stressors or pressures on the family? Explain if yes. |       |
| Primary language spoken by student: |       |
| Other languages spoken in the home: |            |
| **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. |  [ ]  No [ ]  Yes:        |
| The baby was born: | [ ]  Full-term [ ]  Premature:       [ ]  LateBirth weight:        |
| Did the baby breathe on his/her own right away? | [ ]  Yes [ ]  No |
| APGAR scores: | One minute:       Five minutes:       |
| Were any delivery complications or birth defects noted? Explain if yes. | [ ]  No [ ]  Yes:       |
| Where forceps or suction used in the delivery? | [ ]  Yes [ ]  No |
| 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? |  [ ]  Yes [ ]  No |
| 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)? Explain if yes. |  [ ]  No [ ]  Yes:       |
| Has the child ever had speech language 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? Does the child have any difficulties getting or keeping friends? Explain if yes. |  [ ]  No [ ]  Yes:       [ ]  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. |
| **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 |
| 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: [ ]  No [ ]  Yes:       |
| Describe any head injuries (e.g., date, what happened, changes in behavior after the injury). | [ ]  No [ ]  Yes:       |
| List any hospitalizations or surgeries |  [ ]  None List hospitalizations with dates: [ ]  No [ ]  Yes:       |
| 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:      Medication:       Dosage:       How often:       |
| Current medications, dosage, and reason: | Medication:       Dosage:       How often:      Reason:      Medication:       Dosage:       How often:      Reason:      Medication:       Dosage:       How often:      Reason:      Medication:       Dosage:       How often:      Reason:       |
| Has the child ever had a problem with: | [ ]  Social skills[ ]  Abdominal pains/vomiting[ ]  Headaches[ ]  Sleep difficulties[ ]  Eating difficulties[ ]  Aggression[ ]  Noncompliance at home[ ]  Depressed or sullen mood |  [ ]  Impulsivity or hyperactivity [ ]  Temper tantrums[ ]  Worrying or nail biting[ ]  Clumsiness[ ]  Self-injurious behavior[ ]  Forgetfulness[ ]  Noncompliance at school[ ]  Suicidal feelings or actions |
| **Social History Update** |
| Check the following behaviors that describe the child: | [ ]  Self-conscious[ ]  Feels inferior[ ]  Short attention span[ ]  Fails to finish tasks[ ]  Argues, quarrels[ ]  Unusual fears[ ]  Daydreams[ ]  Lacks self-confidence[ ]  Brags, boasts[ ]  Distractible | [ ]  Restless [ ]  Impulsive[ ]  Concerned with bodily changes [ ]  Overexcited easily[ ]  Sulks and pouts[ ]  Rapid mood swings [ ]  Overactive [ ]  Listless [ ]  Changeable [ ]  Bullying others [ ]  Being bullied  |
| Check factors affecting family: | [ ]  Blended family problems[ ]  Unemployed[ ]  Divorce/separation[ ]  Frequent moves[ ]  Incarcerations  | [ ]  Parent-child conflict [ ]  Sibling conflict[ ]  Custody problems[ ]  Parent conflict |
| Do any family members have a history of problems learning? Explain if yes. | [ ]  No [ ]  Yes:       |
| Does anyone in the family have a problem similar to the child’s? Explain if yes. | [ ]  No [ ]  Yes:       |
| 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:       [ ]  No [ ]  Yes Does the school have a copy of the evaluation: [ ]  No [ ]  Yes  |
| Is there any family history of mental health problems? Describe if yes. |  [ ]  No [ ]  Yes:       |
| Describe the child’s attitude toward school? |       |
| Describe the child’s choice of friends (how many, what age, do they get along well)? |       |
| What are your child’s activities when not in school? |       |
| List your child’s chores and responsibilities at home. |       |
| What are your goals for your child’s future? |       |
| **Consulting Professionals & Other Professionals** |
| Please list all others involved in the child’s care, including physicians, psychologists, social workers, therapists, DCS case workers, or probation officers: | Name/Profession:       Nature of their involvement:                                                                    |
| **Child’s Strengths/Additional Comments** |
| Please use this space to note the child’s strengths:  |       |
| Please use this space to note the child’s weaknesses:  |       |
| Please use this space to note any additional comments:  |       |