**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/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 [ ]  Other |
| The child’s parents are: | [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Never married |
| Please list all siblings, including full, half and step-siblings. | Name: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes No |
| 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: weeks early [ ]  LateBirth weight: lbs. oz. |
| 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:  |
| 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: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: | [ ]  Inappropriate/deficient social skills[ ]  Abdominal pains/vomiting[ ]  Headaches[ ]  Sleep difficulties[ ]  Eating difficulties[ ]  Aggression[ ]  Noncompliance at home[ ]  Depressed or sullen mood | [ ]  Impulsivity or hyperactivity [ ]  Temper tantrums[ ]  Anxiety/worry[ ]  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 |
| Describe significant events of concerns affecting your child: |  |
| 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: [ ]  Yes [ ]  No Does the school have a copy of the evaluation: [ ]  Yes [ ]  No  |
| 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/Weaknesses** |
| 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:  |  |
| **Current Preschool Information** |
| Name of preschool attending: |  |
| Child attends school: | [ ]  Full time [ ]  Part timeNumber of days per week: What time of day: |