**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  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 No  Name: Age: Living with child? Yes No  Name: Age: Living with child? Yes No  Name: Age: Living with child? Yes No  Name: 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  Late  Birth 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 time  Number of days per week:  What time of day: | | |