SOCIAL DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. General Information

Student's Name:		Birthdate:	/ /	Age:	

School:		Grade:		Sex:	Female	Male

Current Address:		City/State:		Phone:	( ) –

Ethnic Background (**Bold** or Highlight)	American Indian or Native American	Asian or Pacific Islander	Hispanic	Black American	White	Multiracial

Person Providing this Information (**Bold** or Highlight)	Biological Mother	Biological Father	Foster Parent	Stepmother	Stepfather	Adoptive Parent	Other:

Who does the child live with? (**Bold** or Highlight)	Both Parents	Mother	Father	Other:

Mother's Name:	Age:	Education:
Occupation:	Phone (Home): Phone (Cell):	

Father's Name:	Age:	Education:
Occupation:	Phone (Home): Phone (Cell):	

Stepmother's Name:	Age:	Education:
Occupation:	Phone (Home): Phone (Cell):	

Stepfather's Name:	Age:	Education:
Occupation:	Phone (Home): Phone (Cell):	

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Guardian's Name:	Age:	Education:
Occupation:	Phone (Home): Phone (Cell):	

Marital Status of Parents:			
If separated or divorced, how old was the child?			
Who has custody of the child?		Does the child have contact with the non-custodial parent?	

How often does the non-custodial parent see this child?	Weekly	Monthly	Few Times a Year	Never

Are there other adults who have a ***significant*** part in raising your child?	Yes	Whom?	No

Have there been any significant changes in the home over the last few years? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc.)? If yes, please explain.	

Please list all people in child's immediate family:

Name	Age	Sex	Relationship to Child	Living in home?	Living Outside of home?

Describe the child's relationship with siblings or others in the home.	

Primary language spoken in the home		Other languages spoken in the home.	

II. **Present Performance**

List your child's strengths:	
List your child's interests:	
List your child's weaknesses:	

Briefly describe your concerns:	

How long has this problem been a concern?		Any family members with like problems?	

If yes, list name and relation:	

Has the child received evaluation or help for the current problem?	

If yes, list when and with whom?	

III. **Health and Development**

A. **Pregnancy and Birth**

Mother's age at birth?		Did mother receive routine medical prenatal care?	

Please specify any medications used during pregnancy and the reason used:	

Pregnancy lasted:	weeks/months	Child's birth weight:	pounds	ounces

Birth defects or complications:	

Did the child go home from the hospital at the same time as the mother?	Yes	No

If no, explain why:	

Please **Bold**/Highlight the conditions below that describe the health of the child and mother during…

Mother's Pregnancy	Child's Delivery	Child's Condition at Birth
● No complications ● Blackouts ● Falls ● Physical injury ● Excessive bleeding ● Hypertension ● Diabetes ● Emotional stress ● Toxemia ● Alcohol and/or drug use ● Use of tobacco ● Other:	● Normal ● Induced labor ● C-section ● Breech birth ● Unusually long labor (>12 hours) ● Premature # of weeks ● Overdue # of weeks ● Other problem (specify):	● Normal ● Lack of oxygen ● Breathing problem ● Birth injury/defect ● Jaundice ● Newborn ICU # of days ● Other problem (specify):

B. **Development**

At what age did the child do the following:

Sit Alone:	Speak first words:	Speak in sentences (2-3 words):
Crawl:	Walk Alone:	Toilet Trained:

Did the doctor indicate any developmental problems during the child's first three years of life?	Yes	No

If yes, please explain:	

C. **Health**

How would you describe your child's current health?	Excellent	Good	Fair	Poor

Has your child had any of the following? Please **BOLD**/Highlight if yes.	Please describe and give details, dates, and/or age of onset:
Serious Illnesses	
Head Injuries	
Seizures or convulsions	
Surgery/Hospitalization	
History of Ear Infections	
Allergies and/or Asthma	
Frequent Nightmares and/or Bedwetting	
Frequent/Severe Headaches	
Attention Deficit Hyperactivity Disorder	
Sleeping Problems	
Diabetes	
Broken Bones	
Suicide Attempts	
Other:	

Other important medical information:	

Is your child currently taking any medication?	Yes	No

Medication	Dosage	Dispensed at Home/School	Diagnosis/Reason

Child's Physician:	

Has your child ever been identified as having a disability?	Yes	No

By whom, what age, & what disability?	

D. Special Factors

Vision:			**Hearing:**		
No Apparent Problem			**No Apparent Problem**		
Yes	No	Vision Examination:	Yes	No	Headring Exam
Date:		By:	Date:		By:
Yes	No	Wears glasses/contacts	Yes	No	Has Surgery
Yes	No	Had Surgery	Yes	No	Ear Infections/Frequency
Other (specify):			Yes, Age:	No	Hearing Loss/Age of Loss
			Other (specify):		
Gross/Fine Motor Skills:			**Communication:**		
No Apparent Problem			**No Apparent Problem**		
Yes	No	OT/PT Exam	Yes	No	Speech/Language Exam
Date:		By:	Date:		By:
Yes	No	Walking, jumping, running problems	Yes	No	Problems expressing thoughts
Yes	No	Cutting, Writing, Coloring problem	Yes	No	Problems pronouncing words
Yes	No	Coordination of feeding/dressing	Yes	No	Initiates and Sustains conversation
Yes	No	Repetitive use of Language	Yes	No	Sustains eye contact
Left	Right	Dominance	Other, specify:		

III. Behavior

Social Behavior

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does your child associate w/ scholars or troublemakers?)	
How does your child interact with children in the neighborhood?	
How does your child get along with adults?	

Have you noticed any unusual social interactions, such as non-functional ritual routines, lack of social awareness?	Yes	No

If yes, please explain:	

IV. **Educational History**

How does your child feel about school?	

Has your child ever repeated a grade?	No	Yes	If yes, which grade?	

Describe your child's strengths at school.	
Describe your child's weaknesses in school:	
How motivated do you feel your child is to learn?	
About how much time does your child spend on homework each night?	
How much of a struggle is homework?	

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)?	Yes	No

If yes, what services, when did they begin?	

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare	
Elementary School	
Middle School	
High School	

Agencies that have provided services:	Dates	Reason
Private Tutoring/First Steps		
Private Counseling or Therapist (Specify)		
Community Service Agency (Specify)		
Mental Health Agency		
Department of Children and Family		
Court System		
Day Treatment Program (Specify)		
Inpatient Psychiatric Hospital (Specify)		

Other information you believe may be relevant in the evaluation of your child:	

Name of Person Completing this Form:	Date: