RIPLEY-OHIO-DEARBORN
SPECIAL EDUCATION COOPERATIVE
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Social and Developmental History

Date: _____ Completed By: _____ Relationship to Child:_____

General Background/Family History

First Name: _____ Middle Name:_____ Last Name:_____

Birthdate: _____ Age: _____ Gender: □ Male □ Female

Address: _____

_____

The child lives with: □ Both biological parents □ Mother □ Father

□ Other (List) _____ Relationship _____

School: _____ Teacher: _____ Grade: _____

School District:_____

Mother's Name: _____ Age: _____

Address: _____ Phone (H) _____

_____ Phone (W)_____

Email (optional)_____ Phone (C)_____

Father's Name: _____ Age: _____

Address: _____ Phone (H) _____

_____ Phone (W)_____

Email: (optional)_____ Phone (C)_____

What is the best phone number to reach you **during school hours?** _____

Primary language spoken in the home by caregivers: _____ by the child:_____

The child is:

□ American Indian □ Asian □ Hispanic □ Hawaiian/Pacific Islander
□ African American □ White □ Multi-Racial

Child's Name: _____ *Date of Birth:* _____

The biological parents are: □ Never married to each other □ Married to each other
□ Separated from each other □ Divorced

Is any parent deceased? □ No □ Yes If so, whom?_____

Was your child adopted? □ No □ Yes Date of Adoption: _____

Who has custody of the child? _____

Who has the legal authority to make educational decisions for this child? _____

List all persons living in the child's home:

Name	Age	Relationship to Child	Occupation/Employer

Family History of:

□ Learning difficulties □ Attention-Deficit/Hyperactivity Disorder
□ Speech-Language Difficulties □ Seizures □ Autism/Asperger's Syndrome
□ Substance Abuse □ Depression □ Mental Health Issues _____

Birth and Developmental History

Was the mother under a doctor's care during the pregnancy? □ Yes □ No

Were there any complications during the pregnancy? □ Yes □ No

If yes, please list the complication:_____

Check how frequently the biological mother used the following items during pregnancy with this child:

Tobacco products	□ Never	□ Sometimes	□ Often
Alcohol	□ Never	□ Sometimes	□ Often
Over-the-counter drugs	□ Never	□ Sometimes	□ Often (list_____)
Other drugs	□ Never	□ Sometimes	□ Often (list_____)

Delivery: □ Full Term (38 wks or later) □ Pre-Term; If so, # of weeks _____
□ Head first □ Breech □ Labor Induced □ Forceps/Vacuum Used
□ C-Section Reason for C-Section: _____

Were there any problems before, during, or immediately after birth? □ No □ Yes If yes, please explain:_____

_____

Child's Name: _____ *Date of Birth:* _____

Birth weight: _____ pounds _____ ounces Length of pregnancy: _____ weeks

Did the child require any of the following: □ **None**

□ Apnea monitor How long? _____
□ Incubator How long? _____
□ Bilirubin lights/blanket How long? _____
□ Supplemental oxygen How long? _____
□ Ventilator How long? _____
□ Transport to another hospital Reason: _____
□ Other _____

Developmental Skills:

Yes	No	My child:	Yes	No	My child:
□	□	sat alone between 6 - 8 months	□	□	spoke first word between 6 - 18 months
□	□	crawled between 8 - 10 months	□	□	spoke in sentences between 2 - 3 years
□	□	walked between 10 - 16 months	□	□	toilet trained between 2 - 4 years
□	□	ate finger foods between 8 - 12 mos	□	□	dressed self between 2 - 4 years

Compared to other children his/her age, my child's motor development has been:
□ slower □ about the same □ faster

Compared to other children his/her age, my child's speech/language development has been:
□ slower □ about the same □ faster

Medical History:

Child's Physician: _____ Date of Last Examination: _____

Location of Office: _____

Has the physician been contacted concerning any school problems? □ No □ Yes

If yes, what were the physician's findings? _____

	Hearing	**Vision**	**Speech**
Has your child experienced problems with:	□ No □ Yes	□ No □ Yes	□ No □ Yes
Was this checked by a physician in the past 2 years?	□ No □ Yes	□ No □ Yes	□ No □ Yes
Date of Last Exam:	_____	_____	_____

Hearing My child:

□ asks people to repeat or talk louder □ is startled at sudden noises
□ had or has chronic ear infections □ is under doctor's care (Doctor's name: _____)
□ had or has surgical tubes □ left ear □ right ear (date/dates)_____
□ wears a hearing aid □ left ear □ right ear
□ has a cochlear implant (date/dates) _____

Child's Name: _____ *Date of Birth:* _____

Vision My child:

□ shows signs of eyestrain □ squints
□ is nearsighted □ is farsighted
□ wears glasses (date) _____ □ is under doctor's care (Name: _____)
□ had corrective eye patching □ left eye □ right eye (date/dates) _____

Speech/Language My child:

□ does not speak □ has difficulty saying some sounds or words
□ has difficulty expressing wants and needs □ participates in "give and take" conversations
□ gives appropriate answers to questions □ gives eye contact

Does your child have a medical diagnosis? (If yes, please list.) _____

_____

_____

Is your child currently taking prescription medicine? □ No □ Yes

Medication	Dosage	Date(s) Taken	Reason	Side Effects

Has your child had any surgeries or hospitalizations? □ No □ Yes

Date	Reason	Length of Stay

Check if your child has, or had in the past, any of the following problems:

□ Allergies (Describe: _____)

□ Asthma □ Headaches □ Heart problems
□ Bedwetting □ Headbanging □ Lead poisoning
□ Bladder problems/Bowel problems □ Loss of consciousness □ Physical growth problems
□ Colic □ Nervousness □ Seizures
□ Dizzy spells □ Fatigue □ Sleeping problems
□ Eating problems □ Frequent illness □ Other _____

Child's Name: _____ *Date of Birth:* _____

Social, Emotional, and Behavioral History

Check if your child has experienced problems with any of the following: ☐ **No concerns in this area**

☐ Anger control	☐ Extreme mood swings	☐ Short attention span
☐ Anxiety/nervousness	☐ Unusual fears: _____	☐ Poor concentration
☐ Cries easily	☐ Fidgets and squirms often	☐ Risk-taking behaviors
☐ Depression	☐ Fights	☐ Impulsivity
☐ Difficulty starting tasks	☐ Difficulty finishing tasks	☐ Following instructions
☐ Excessive talking	☐ Dwells on one thought	☐ Losing things often
☐ Tantrums: How often? _____	☐ Verbal aggression	☐ Physical aggression
☐ Easily distracted	☐ Easily frustrated	☐ Overactive / restless
☐ Peer relationships	☐ Has mentioned suicide	☐ Other _____
☐ Bullies others at school	☐ Has been bullied at school	

Please explain any of the items checked: _____

_____

_____

_____

_____

Check if your child has experienced any of the following events that may have affected his/her social, emotional, or physical growth. Include approximate dates if known: ☐ **None of these events**

☐ Accident	_____	☐ Illness	_____
☐ Abuse (circle - Emotional - Physical - Sexual)	_____	☐ Move	_____
☐ Change of guardian	_____	☐ Parent job loss	_____
☐ Death of family member	_____	☐ Parent remarriage	_____
☐ Parent divorce	_____	☐ Parent separation	_____
☐ Conflict between parents	_____	☐ Sibling problem	_____

Please explain any of the items checked: _____

_____

_____

Who primarily disciplines your child? _____

Is it difficult to discipline your child? ☐ Yes ☐ No If yes, explain as fully as possible:

_____

_____

What form of discipline is used in the home? _____

Child's Name: _____ *Date of Birth:* _____

Has your child been diagnosed with any of the following?: ☐ **No diagnosis**

☐ Attention-Deficit/Hyperactivity Disorder (ADHD)
☐ Anxiety
☐ Bipolar Disorder
☐ Depression
☐ Eating Disorder
☐ Autism
☐ Oppositional Defiant Disorder (ODD)
☐ Asperger's Syndrome
☐ Obsessive/Compulsive Disorder (OCD)
☐ Reactive Attachment Disorder
☐ Other _____

Socialization Does your child:

Yes	No	
☐	☐	Have opportunities to socialize with other children his/her age?
☐	☐	Pick up social cues from others, such as interpreting facial expressions/body language or understanding what is being asked or stated?
☐	☐	Get along well with other children?
☐	☐	Have difficulty making friends?
☐	☐	Adjust well to changes in activities or routines?
☐	☐	Identify his/her own emotions and recognize those of others?
☐	☐	Maintain an appropriate distance when interacting with peers?
☐	☐	Work well in a group?
☐	☐	Exhibit fear or anxiety in social situations?

Play/Leisure Activities

Does your child prefer to play alone or with others? _____

If your child could choose anything he/she likes to do, he/she would choose: _____

_____

For younger children:

Does your child have favorite toys? _____

Does he/she play appropriately with toys? _____

Does your child use his/her imagination to play? _____

Responses to Sensory Experiences

My child: ☐ **No concerns in this area**

☐ Craves touch or needs to touch everything and everyone
☐ Is overly sensitive to stimulation, overreacts to/does not like touch, noise, smells, textures, lights, etc.
☐ Is bothered by tags in clothing, clothes rubbing on skin, or wearing socks or shoes
☐ Has a low tolerance for pain
☐ Has a high tolerance for pain
☐ Is a picky eater, only eating certain foods; resists trying new foods
☐ Has difficulty with fine motor tasks; cutting with scissors, writing, using utensils
☐ Loses balance easily and/or appears clumsy
☐ Has poor gross motor skills; jumping, catching a ball, climbing, poor balance, etc.
☐ Misjudges how much pressure or force to use
☐ Often does not respond to his/her name being called
☐ Avoids eye contact

Child's Name: _____ *Date of Birth:* _____

School History

Starting with preschool, please list the schools your child has attended:

School Location Grade Level

_____

_____

_____

_____

_____

Has your child repeated any grades? □ No □Yes If yes, which one(s)? _____

Has your child ever been tested for special education? □ No □ Yes If yes, when? _____

Do you feel your child is experiencing problems in school? □ No □ Yes

What do you think your child's primary difficulties are: _____

_____

_____

When did you first become aware of the problem? _____

What do you think is causing the problem? _____

_____

Has your child mentioned problems at school? How does he/she feel about the problem? _____

_____

List subjects that are easy for your child. _____

List subjects that are hard for your child. _____

Does your child usually complete homework? □ No □ Yes

Estimate the average time spent on home assignments each day _____

Check if your child has received any of the following services:

□ Speech-language therapy □ Physical therapy □ Occupational therapy

□ Title 1 □ Reading Recovery □ Tutoring

□ Other _____

Child's Name: _____ *Date of Birth:* _____

Community Supports

What individuals or agencies are currently involved or have been involved with your child?

	Name/Location	Contact Person
First Steps		
Community Preschool		
Head Start		
Counseling		
Community Mental Health Center		
Inpatient Mental Health Hospitalization		
Division of Family and Children		
Juvenile Center		
Probation Department		
Other		

What are some of your child's strengths? _____

_____

What are your hopes or goals for your child? _____

_____

Is there anything else you would like us to know about your child? Attach additional sheets if needed:_____

_____

_____

_____

_____

_____

_____

_____

_____