Burke Basic School

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Social and Developmental History

The following questions concern your child's development and functioning within your family. Your answers will provide us with information as part of the comprehensive evaluation. This will be useful in understanding factors, which have had an influence on your child's growth and achievement in school. Thank you for your cooperation in completing this form.

Student Information

Child's Full Name: _____ Gender: M F DOB: ___/___/___

Ethnicity: _____ Grade: K 1 2 3 4 5 6

Home Address: _____ Phone Number: (_____) _____-_____

_____ Circle One: Home Cell Other

Language Used at Home: _____ Language Spoken by Student: _____

Form Completed by: ☐ Mother ☐ Father Other: _____

Household Members:

Name	Age	Relationship to Child

PRENATAL HISTORY

2. Did the mother visit the doctor regularly during pregnancy? Y N
   How often: _____

3. Were there any difficulties during pregnancy? Y N
   If yes, please describe: _____

4. Did the mother take any medications and/or drugs during pregnancy? Y N
   If yes, please describe: _____

5. Did the mother smoke during pregnancy? Y N
   If yes, how much? _____

6. Did the mother consume alcohol during pregnancy? Y N
   If yes, how much? _____

7. Were there any difficulties during delivery? Y N

Length of labor _____ Premature labor? Y N

Type of birth: Vaginal Caesarian Trauma to infant? Y N

Birth weight: _____ lbs _____ ozs. Trauma to mother? Y N

8. Were there any difficulties during infancy? Y N

If yes, please describe: _____

DEVELOPMENTAL HISTORY

9. When did your child begin the following:

Sitting without support	☐ Before 5 months	☐ 5-8 months	☐ After 8 months
Crawling	☐ Before 6 months	☐ 6-9 months	☐ After 9 months
Walking unassisted	☐ Before 10 months	☐ 10-18 months	☐ After 18 months
First word	☐ Before 10 months	☐ 10-16 months	☐ After 16 months
Talking in sentences	☐ Before 15 months	☐ 15-36 months	☐ After 36 months
Toilet Trained	☐ Before 24 months	☐ 24-40 months	☐ After 40 months

MEDICAL HISTORY

10. Has your child had any of the following (if yes, indicate when and what occurred):

Chronic ear infections:	*Y*	*N*	*Frequent colds and/or infections:*	*Y*	*N*
Tubes in ears:	*Y*	*N*	*Unusual illnesses:*	*Y*	*N*
Hearing problems:	*Y*	*N*	*Serious accidents:*	*Y*	*N*
Surgery/ Hospitalizations:	*Y*	*N*	*Seizures/ convulsions:*	*Y*	*N*
Respiratory Illnesses	*Y*	*N*	*Allergies:*	*Y*	*N*
High fevers:	*Y*	*N*	*Asthma:*	*Y*	*N*
Vision Problems:	*Y*	*N*	*Glasses:*	*Y*	*N*
Regular dental visits:	*Y*	*N*	*Dental problems:*	*Y*	*N*

Please explain any "yes" answers: _____

EDUCATIONAL HISTORY

11. Did your child attend: ☐ daycare ☐ preschool ☐ kindergarten

12. List the all of the schools (K-12) your child has attended:

School	City, State	Grade

13. Has your child ever received failing grades: Y N Subject(s): _____

14. Has your child ever repeated a grade: Y N If yes, which grade(s): _____

15. How is your child's attendance: Excellent Good Fair Poor

16. Has your child ever been suspended: Y N If yes, explain: _____

17. Has your child participated or been referred for any of the following programs or services through school or an outside agency? Check all that apply

☐ Retained a Grade ☐ English Language Learners ☐ Special Education

☐ Physical Therapy ☐ Psychological Evaluation ☐ Educational Evaluation

☐ Counseling ☐ Speech/ Language Therapy ☐ Gifted Classes

☐ Occupational Therapy ☐ Other Evaluations

If yes to any of the above, please indicate when and where:

_____

_____

_____

SOCIAL/ EMOTIONAL HISTORY

18. Please indicate the following about your child:

General disposition/ temperament: Easy-going Difficult Shy/Slow to warm up

General physical activity level: High Average Low

Response to stress/ frustration: Becomes angry Withdraws Bites nails Shakes

Sucks thumb Other: _____

Response to changes in routine: Adapts well Slightly agitated Becomes very upset

19. Please indicate how well your child gets along with:

Parents:	well	okay	poorly
Siblings:	well	okay	poorly
Peers:	well	okay	poorly

20. Do any of the following behaviors or characteristics apply to your child. Please check all that apply:

☐ Physically Aggressive	☐ Verbally Aggressive	☐ Nightmares	☐ Bedwetting
☐ Overeating	☐ Undereating	☐ Low self- esteem	☐ Moody
☐ Non- compliant	☐ Disorganized	☐ Tantrums	☐ Substance abuse
☐ Impulsive	☐ Easily Distracted	☐ Perfectionist	☐ Forgetful
☐ Sleeps too much	☐ Sleeps too little	☐ Short attention span	☐ Manipulative
☐ Acts without thinking	☐ Always moving	☐ Anxious	☐ Skips school

☐ Talks of hurting self or others ☐ Tics/ nervous gestures ☐ Doesn't respect authority
☐ Unkempt appearance ☐ Depressed ☐ Frequent stomach issues

21. Please list any concerns you have about your child's academic performance, social skills, or behavior.

22. Please list your child's interests: _____

23. Please lists your child's greatest strengths: _____

24. Please list any areas of difficulty for your child: _____

25. Does your child have chores? Y N Please list: _____
Does he or she complete them regularly? Y N Without prompting? Y N

26. What ways work to discipline or correct your child? _____

FAMILY HISTORY

27. Within the past year (12 months), has your child or anyone in your immediate family/household experienced any of the following changes? Please explain any yes answers.

☐ Moved: _____

☐ Change of schools: _____

☐ Marriage: _____

☐ Divorce: _____

☐ Separation: _____

☐ Serious Illness/ Accident: _____

☐ Legal problems: _____

☐ Death: _____

☐ Drug/ Alcohol Abuse: _____

☐ Victim of Violence/ Abuse: _____

☐ Change of Financial Status: _____

☐ Change of Employment: _____

☐ Unemployment: _____

☐ Other: _____

28. Did any of the previous occur within the last 2 to 3 years.

Please list & explain: _____

_____

_____

_____

29. Do you have any questions or concerns you want to share with the evaluation team?

_____

_____

_____

_____

_____

_____ _____

Signature Date