Joint Educational Services in Special Education
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JESSE EARLY CHILDHOOD/PRESCHOOL PROGRAM
SOCIAL AND DEVELOPMENTAL HISTORY
COMPREHENSIVE

Child's Name: _____ Gender: M F
Birthdate: _____ Age: _____ Ethnicity: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Date Completed: _____ Email Address:_____
Person completing this form: _____ Relationship to Child: _____
What concerns you about the child that prompted you to request this evaluation? _____
_____
_____
_____
How long has this problem been of concern to you? _____
Are there family members with the same problems? _____
If yes, list names and relation: _____
Has the child been evaluated or received help for the current or similar problems? Y N If yes, list when and with whom: _____
List the child's strengths:_____

_____
List the child's interests: _____
_____
Name of the child's Primary Doctor: _____ Phone: _____
Other Doctors involved: _____ Phone: _____
_____ Phone: _____

Family Information:
Mother's Name: _____ Age: _____ Education: _____
Occupation: _____ Phone: _____
Father's Name: _____ Age: _____ Education: _____
Occupation: _____ Phone: _____
Names and Ages of Child's Brothers and Sisters:

Name	Age	Home?	Name	Age	Home?
_____	_____	Y N	_____	_____	Y N
_____	_____	Y N	_____	_____	Y N
_____	_____	Y N	_____	_____	Y N

Describe the child's relationship with siblings or others in the home?
_____ With whom does your child live?
_____ Are there any languages other than English spoken in the home? Y N If so, please specify: _____
Have there been any significant changes in family status in the last2-3 years? (i.e.: marriage, birth of siblings, divorce, death) Y N Please describe:_____

Family History:

Check illness or condition that any family member has had. Identify family member's relationship to the child

__Academic Problems_____ __Emotional Problems_____
__Alcoholism_____ __Epilepsy_____
__Cancer_____ __Heart Trouble_____
__Depression _____ __Neurological Disease_____
__Developmental Problems _____ __Suicide Attempt_____
__Diabetes_____ __Other Medical Issues_____
__Drug Problems_____ _____

Medical History:

According to the doctor, was there anything unusual during the pregnancy? Y N If so, list conditions present during pregnancy: _____

_____

Was the child: _____ Full term _____ Premature – number of weeks early _____ _____ Overdue

Birth Weight: _____ lbs _____ oz Current Weight: _____ lbs

Does the child had a history of any of the following: _____ Ear Infections _____ Tonsils and Adenoids removed

_____ Chronic Colds _____ High Fevers _____ Seizures _____ Swallowing or Chewing Problems

Has the child have a medical diagnosis? If so, what? _____

List any hospitalizations, surgeries, orthopedic interventions (soft tissue lengthening, tendon transfers, baclofen pump, botox injections, etc.) _____

_____

Is the child on any medications? Y N If so, please provide the name(s) of the medication(s) and what they are for:

_____

_____

List any serious accidents involving the child: _____

_____

Developmental History:

Has your child independently mastered any of the following skills and if so, at what age?

Sat alone _____ Crawled _____ Walked alone _____ Stood alone _____ Toilet Trained_____

Dressed Self _____ Fed self with fingers _____ Fed self with spoon or fork _____

Said first words: _____ Said first sentences: _____

Did the child babble or make play noises during infancy? Y N

Vision:

Has the child's vision been screened? Y N Results: _____

Do you have concerns about the child's vision? Y N Explain: _____

Hearing:

Has the child ever had a hearing test or screening? Y N If so, what were the results?_____

Has the child had PE tubes inserted? Y N If yes, how many times and at what age(s)? _____

Speech and Language Development:

When did the child speak his/her first words? _____

How does the child request/make his/her needs known? Give Examples: _____

_____

Does the child have swallowing or feeding difficulty? Y N If yes, please describe: _____

_____

Does he/she name people and/or objects in his/her environment? Y N Explain:_____

Does the child attempt to imitate speech? Y N Explain: _____

How much of what the child says can you understand? _____

Can he/she follow single step directions? Y N Give examples:_____

Does the child follow a 2-step direction? Y N Give examples:_____

Does the child scream or make unusual noises? Y N If yes, please describe:_____

Can he/she listen to a story? Y N For how long?_____

Can the child retell a story? Y N In how much detail?_____

_____

What kinds of questions will your child answer? Y N Give examples:

_____

_____

Is the child aware that his/her speech is different from peers? Y N If yes, how does he/she react?_____

_____

Observation at Play:

How does the child learn a new activity? Does he/she learn by watching or do they need physical assistance?

_____

After learning an activity, does he/she need help to remember how to do it? YES NO NOT SURE

Does the child use primarily one hand when eating, coloring and throwing, or does he/she switch hands frequently?

_____ Right _____ Left _____ Switches

When your child holds toys, crayons, or utensils, does he/she use finger tips or the whole hand?

_____

_____

How long does the child sit and play?_____

What toys does the child like to play with? _____

Behavior:

Does the child have any unusual fears or problems? YES NO NOT SURE

If yes, please explain:_____

Do you think the child is overly active and restless? YES NO NOT SURE

How would you describe the child's personality? _____

_____

What are some of the child's favorite activities? _____

Does the child change from one activity to another with ease? YES NO NOT SURE

Does the child demonstrate a short attention toward desired activities? YES NO NOT SURE

What jobs or chores does the child actively participate in with minimal assistance? (example: put socks away, making bed, setting table). _____

_____

_____

Sensory:

Is the child bothered by getting messy?	YES	NO	NOT SURE
Is the child bothered by clothing textures or tags?	YES	NO	NOT SURE
Is the child bothered by loud or unexpected noises?	YES	NO	NOT SURE
Is the child bothered by smells?	YES	NO	NOT SURE
Does your child like a variety of foods?	YES	NO	NOT SURE
Is your child overly active?	YES	NO	NOT SURE

Fine Motor:

Does the child stack blocks?	YES	NO	_____ How Many?
Does your child scribble on a picture?	YES	NO	NOT SURE
Does the child copy vertical and horizontal lines?	YES	NO	NOT SURE
Does your child snip paper with scissors?	YES	NO	NOT SURE
Can your child unscrew the lid of a jar?	YES	NO	NOT SURE
Can your child work a puzzle?	YES	NO	NOT SURE

Self-help:

Does the child drink from an open cup?	YES	NO	NOT SURE
Does the child use a spoon at meals?	YES	NO	NOT SURE
Can the child undress self?	YES	NO	NOT SURE
Can the child put on clothes?	YES	NO	NOT SURE
Can the child put on shoes?	YES	NO	NOT SURE
Can the child pull pants up/down for toileting?	YES	NO	NOT SURE
Can the child wash own hands with soap?	YES	NO	NOT SURE

Gross Motor:

Can the child jump forward with both feet?	YES	NO	NOT SURE
Can the child kick a ball?	YES	NO	NOT SURE
Can the child walk up and down stairs with a handrail?	YES	NO	NOT SURE
Can the child walk across a low balance beam?	YES	NO	NOT SURE
Can the child pedal a tricycle?	YES	NO	NOT SURE
Can the child throw a small ball forward?	YES	NO	NOT SURE
Can the child run without difficulty?	YES	NO	NOT SURE
Can he/she safely access outdoor playground equipment?	YES	NO	NOT SURE

Education:

List Preschools/Day Cares attended:

_____ Dates:_____

_____ Dates:_____

Does the child enjoy school?	YES	NO	NOT SURE
Does the child do well in school?	YES	NO	NOT SURE

If no, please explain_____

Agencies or therapists that have worked with the child (speech, occupational, or physical)

Name	Phone Number	Type of Therapy	Frequency	Dates

_____

_____

_____

Please add any additional information you feel would help us to know your child better on the back of this page.

Medical Equipment:

Orthotics/Splints: Does your child currently wear orthotics? _____ YES _____ NO

If not, has he/she ever worn them in the past? _____ YES _____ NO

Type	Date Received	Type	Date Received
_____ AFO	_____	_____ SMO	_____
_____ shoe insert	_____	_____ hand splint	_____

_____ Other (please specify)_____

Adaptive/Durable equipment: Does the child use/have any of the following medical equipment? Please check

_____ walker _____ gait trainer _____ stander _____ wheelchair

_____ adaptive chair/seating (such as: feeding chair, potty chair, bath chair, comfort leisure seating)

_____ Other (please specify)_____

Other Medical Equipment:

_____ eyeglasses _____ hearing aids _____ tracheostomy _____ suction machine

_____ G-tube _____ inhaler _____ nebulizer _____ ureterostomy

_____ Other (please specify)_____