# Joint Educational Services in Special Education

## INITIAL SOCIAL AND DEVELOPMENTAL HISTORY

Child's Name _____ Birthdate_____ Age_____

School _____ Grade _____ Sex: _____Male _____Female

Home Address_____ Phone _____

Ethnic Background (Circle one): American Indian or Native Alaskan, Asian or Pacific Islander, Hispanic, Black American, White (not Hispanic), Multiracial

Person completing this form: (Circle one): Natural Mother, Natural Father, Foster Parent, Stepmother, Stepfather, Adoptive Parent or Other (Please explain):_____

Date Form Completed _____ Date Form Received by School Psychologist _____

Marital status of parents: _____

If separated or divorced, how old was child at separation _____ at divorce _____

Who has custody of this child? _____ Does the child have contact with the non-custodial parent? _____

How often does the non-custodial parent see this child? (Circle one): At least Weekly, Monthly, Few times each Year, or Never

Is either biological parent deceased? Mother _____ Father _____ If Yes, indicate the year _____

Mother's Name _____Age _____ Education _____

Occupation_____Phone: Home_____ Business_____

Father's Name _____Age_____ Education _____

Occupation_____Phone: Home_____ Business_____

Stepmother's Name _____Age_____ Education _____

Occupation_____Phone: Home_____ Business_____

Stepfather's Name _____Age_____ Education _____

Occupation_____Phone: Home_____ Business_____

List all brothers and sisters, or others living with the family and their relationship to the child.

| Name | Age | Sex | Relationship to child | Living in home? | Living outside home? |
|---|---|---|---|---|---|
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| | | | | | |

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

_____

Has the student been involved in any of the following settings? If yes, indicate the dates: Foster home _____

Group home _____ Correctional Facility _____ Psychiatric Facility _____ Other (specify) _____

Primary language spoken in the home:_____ Other languages spoken in the home: _____

What was the first language learned? _____

If other than English, at what age did your child begin to speak English? _____

Child's Name:_____

## STUDENT'S PRESENT PERFORMANCE

List your child's strengths: _____

_____

_____

List your child's interests: _____

_____

_____

Briefly describe your child's current difficulties: _____

_____

_____

How long has this problem been of concern to you? _____Are there other family members with the same problems? _____

If Yes, list name and relation:_____

Has the child received evaluation or help for the current problem or similar problems? Yes_____ No_____

If Yes, list when and with whom _____

## MEDICAL HISTORY

Is the child on any medication at this time? Yes _____ No _____. If Yes, list information.

| Medication | Dosage | Dispensed at Home | Dispensed at School | Diagnosis and Reason for Medication |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Check all illness or condition(s) that your child has had:

| | | | | | |
|---|---|---|---|---|---|
| _____ Cancer | Age_____ | _____ Allergies | Age_____ | _____ Encephalitis | Age_____ |
| _____ Hospitalization | Age_____ | _____ High Fever | Age_____ | _____ Frequent or Severe Headaches | Age_____ |
| _____ Head injury | Age_____ | _____ Asthma | Age_____ | _____ Unconsciousness | Age_____ |
| _____ Operations or Surgery | Age_____ | _____ Diabetes | Age_____ | _____ Seizure Activity | Age_____ |
| _____ Meningitis | Age_____ | _____ Dizziness | Age_____ | _____ Attention Deficit Disorder | Age_____ |
| _____ Bone/Joint Disease | Age_____ | _____ Broken Bones | Age_____ | _____ Wetting or Soiling Day ____ Night ____ | Age_____ |
| _____ Sleeping Problems | Age_____ | _____ Suicide Attempt | Age_____ | _____ Lead Poisoning | Age_____ |
| _____ Color Blindness | Age_____ | _____ Other (Specify) _____ | | | Age _____ |

Other chronic medical conditions:_____

_____

Please further explain any listed illness or condition:_____

_____

Name of Child's Doctor _____ Address _____

Date of last Physician examination _____ Does the Physician know of the child's school problems? _____

Physician's comments about school problems:_____

_____

Child's Name:_____

## FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any family member has had. When you check an item, list the family member's relationship to the child.

- □ Academic Problems _____
- □ Alcoholism _____
- □ Cancer _____
- □ Depression _____
- □ Developmental Problems _____
- □ Diabetes _____
- □ Drug Problems _____
- □ Emotional Problem _____
- □ Epilepsy _____
- □ Heart Trouble _____
- □ Neurological Disease _____
- □ Suicide Attempt _____
- □ Other Medical Issues _____

_____

## DEVELOPMENTAL FACTORS

**PREGNANCY**: Mark if mother had any of the following during pregnancy:

_____Hospitalizations _____Diabetes _____ Infectious Diseases (List) _____

_____Convulsions _____High Fever _____ Exposure to X-rays or Chemicals

_____German Measles _____Medications (specify): _____

**IS THERE A PRENATAL HISTORY OF MOTHER USING (indicate which trimester)**

Cigarettes 1st ___ 2nd ___ 3rd ___ Alcohol 1st ___ 2nd ___ 3rd ___ Recreational Drugs 1st ___ 2nd ___ 3rd ___

When did the Mother have physician care during pregnancy? 1st ___ 2nd ___ 3rd ___ Prescription or other Drugs 1st __ 2nd __ 3rd __

**BIRTH FACTORS**:

Length of pregnancy: _____ Weight at birth:_____ Was a caesarean (C-section) performed? _____

Prolonged, difficult or forced labor? _____ Birth defects or complications:_____

Were there any special problems within the first month? _____

**EARLY DEVELOPMENT:** At what age did the child do the following:

Sit alone _____ Speak first words _____ Speak in Sentences (2 – 3 words) _____

Crawl _____ Walk alone _____ Have Bladder and Bowel Control _____

Did the doctor indicate any developmental problems during the child's first three years of life? Yes _____ No_____ If Yes, please explain._____

## SPECIAL FACTORS

**VISION**:

____No apparent problem
____Vision Examination
date _____by whom_____
____Wears glasses
____Wears contacts
____Had surgery (specify:_____ age_____)

**HEARING:**

____No apparent problem
____Hearing Examination
date _____by whom_____
____Had surgery (specify _____age_____)
____Ear infections/frequency_____
____Hearing loss/Age of loss_____

**GROSS AND FINE MOTOR:**

____No apparent problem
____OT or PT Examination
date _____by whom_____
____Walking, jumping, running problems
____Cutting, writing, coloring printing problems
____Other (specify _____)

**COMMUNICATION:**

____No apparent problem
____Speech and Language Examination
date _____by whom_____
____Problems expressing thoughts
____Problems pronouncing words
____Other (specify _____)

**SOCIAL**:

How does your child interact with other children? (list any: fights, play groups, friends, trouble, etc.) _____

_____

How does your child get along with adults? _____

_____

Have you noticed any unusual social interactions? Yes_____ No_____ If Yes, please explain: _____

_____

Child's Name:_____

## SCHOOL HISTORY

| Preschool/Grade Level | Name of School | Location |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child been absent from school a lot? Yes _____ No _____ If Yes, please explain: _____

_____

### SCHOOL INTERVENTIONS

| MARK INTERVENTIONS THE CHILD HAS RECEIVED: | YES | NO | GRADES | COMMENTS |
|---|---|---|---|---|
| Repeated Grade | | | | |
| Reading Assistance | | | | |
| Remediation | | | | |
| Speech/Language Services | | | | |
| Counseling or Social Services | | | | |
| Suspension or Expulsion | | | | |
| Summer School | | | | |
| Other (specify) | | | | |

### AGENCY SERVICES

| LIST THE AGENCIES THAT HAVE PROVIDED SERVICES FOR THE CHILD: | DATES | REASON (Provide as much detail as possible; use a separate page if necessary) |
|---|---|---|
| Private Tutoring | | |
| Private Counselor or Therapist (specify) | | |
| Community Service Agency (specify) | | |
| Mental Health Agency | | |
| Department of Children and Families | | |
| Court System | | |
| Day Treatment Program (specify) | | |
| Inpatient Psychiatric Hospital (specify) | | |

What do you think your child needs to do that he/she is not doing now and why? _____

_____

Do you have any other questions or concerns? _____

_____

_____

Any other information which would help us understand your child? _____

_____

_____