McLEAN COUNTY PUBLIC SCHOOLS
Social/Developmental/Health History

Student's Name: ______________________________ **Birth Date** ____________ **Grade** ________

School ____ **Date:** ____________

Person completing form: ______________________________ **Relationship to student:** ______________

FAMILY INFORMATION

Persons Living in the home: (If more room is needed, list on back.)

Name	Age	Relationship to student

FAMILY STATUS:

Biological Parents: Married Divorced Separated Single Widowed

If divorced/separated, how was this handled by your child? ______________________________

If divorced/separated, does the child see the other parent?

Never Sometimes Often

Are there other adults who have an important part in raising your child? If yes, who? ______________________________

SCHOOL HISTORY

Before beginning Kindergarten, did your child attend: Preschool Day Care Head Start

If your child attended schools other than those in McLean County Public Schools District, please list the schools (city, state) and dates attended: ______________________________

Has your child repeated a grade? Yes No (If yes, indicate the grade) ____________

Please check which describes your child's feelings about school:

Likes school Eager/Motivated Fearful/Anxious Dislikes school

Do you have any concerns about your child's school progress (e.g., academic, social, behavioral)? Yes No
If yes, please describe ______________________________

EARLY DEVELOPMENT

Was the child born full-term? Yes No (If not, how many weeks was the pregnancy?) ______________

Was the child adopted? Yes No (If yes, how old was the child when adopted?) __________________

Did the mother experience any of the following during this pregnancy?

Serious illness or injury? (Specify) ____________________________ Alcohol or other drug use

Other: ____

Did your child experience any of the following during delivery?

C-section delivery Low birth weight Delivered with cord around neck

Jaundice Cyanosis (turned blue) Needed Oxygen

Seizures Birth Defect (Specify) __________________________________

Injury (Specify): _______________ Other:_____________________________

How was your child's temperament (e.g., happy, cuddly, fussy, colicky) as a baby? ______________________

Please circle when your child reached developmental milestones*:

Sitting:	Early (3-6 mos.)	Average (7-12 mos.)	Late (over 1 yr.)	Don't know
Walking:	Early (7-12 mos.)	Average (12-18 mos.)	Late (over 18 mos.)	Don't know
Speaking two- to three-word sentences:	Early (9-17 mos.)	Average (18-24 mos.)	Late (over 2 yrs.)	Don't know
Toileting	Early (1-2 yrs.)	Average (2-3 yrs.)	Late (over 3 yrs.)	Don't know

**Age range information from Centers for Disease Control & Prevention (CDC)*

Has your child received any early intervention services (e.g., First Steps)? Yes No

If yes, which of the following? Speech Therapy Occupational Therapy (OT) Physical Therapy (PT)

Developmental Intervention (DI) Other: ____

Do you have any concerns with your child's speech and language skills? Yes No If so, please describe ____________
____

HEALTH & WELLNESS

Does the family have a history of any of the following?

Alcohol or other drug use Anxiety Disorder Depression Bipolar Disorder

Autism Spectrum Disorder Learning/Reading Problems Behavioral difficulties Other: __________

Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

The child's overall health is: Good Fair Poor

How many hours of sleep does your child get a night? _________________________

Does your child have any problems sleeping? Yes No (If yes, specify below)

Difficulty falling asleep Wakes too early Nightmares Loud snoring

Awakens during night Restless sleeper Sleep apnea Bedwetting

Does your child have a pediatrician/primary care provider? Yes No Doctor's name: ______________________

When was your child's last checkup? ________________________________ Any significant findings? Yes No

(If yes, please explain) ____

Medication	Reason
________________________________	____
________________________________	____
________________________________	____
________________________________	____

Have glasses or contacts been prescribed? Yes No Does your child wear them? ______________________

Hearing Problems (describe): ____

Does your child wear a hearing aid? Yes No

Does your child have any other ***medical diagnosis*** (physical or mental)? Yes No (If yes, please explain) _____

____

Has your child been hospitalized for medical treatment? Yes No

When? ____________________________ Why? _________________________________ Hospital____________________

Has your child had a psychological evaluation outside of school? Yes No

When? _________________________________ Why?____________________________ Agency: ___________________

**These hospitals & agencies will not be contacted unless you have signed an Authorization to Disclose Information Form. Your child's records are protected.*

HOME & COMMUNITY

What is the primary language spoken by the parents? ________________________ by the child?_______________________

Temperament of your child: Shy Withdrawn Easy going Difficult

How does your child spend time outside of school?

Reading/Being read to	Play outside	Using the computer	Using the phone
Spending time with family members or friends	Working at a job	Doing homework	Watching TV
Playing with toys or non-electronic games	Playing video games	Other: ______________________________	

How are your child's relationships with the following? (Specify good/fair/poor)

Parents: ________ Other Adults: ________ Siblings: ________ Peers: ________

What are your child's regular chores/household responsibilities? ____

____

What forms of discipline and behavior management are used with your child? Check all that apply.

Time-out	Behavior chart/rewards system	Spanking
Loss of privileges	Grounding	Extra privileges

Other (please describe):____

How does your child usually react to discipline? Complies Complains Does not comply & resists
Indifferent or passive attitude Other: ____

Has your child experienced any of the following stressful events that have impacted the child's academic/social development? (Check if applicable)

- Parents divorced or separated
- Student changed schools
- Parent changed or lost job
- Family accident or illness
- Family moved
- Family financial problems
- Custody change
- Homelessness
- Death in family____
- Addition of family member ____
- Other (please describe): ____

Any additional information or comments:

Signature: ____ Date: ____________________________