

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name _____ DOB _____ Age _____ Grade _____

Classroom teacher _____

Current Address: _____

How long at this address? _____

Person providing information: _____

Relationship to child _____

Who does child live with: both parents mother father other (specify) _____

Biological father _____ Occupation _____ Years education: _____

Father's home phone _____ Work # _____ Cell # _____

Biological mother _____ Occupation _____ Years education: _____

Mother's home phone _____ Work # _____ Cell # _____

If applicable: Guardian's name _____ Occupation _____ Years education _____

Guardian's home phone _____ Work # _____ Cell # _____

Please list all people in child's immediate family: _____

Name Relationship to child Age / Grade Living in house? _____

Please list all other *non-family* members who live in household: _____

Name Relationship to child/family How long has lived in household? _____

Language(s) spoken at home _____

Primary Language at home _____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace _____ Moved at age _____ grade _____

2. _____ Moved at age _____ grade _____

3. _____ Moved at age _____ grade _____

4. _____ Moved at age _____ grade _____

Are biological parents of child currently: married separated divorced never married

• If separated or divorced, who has *legal* custody? mother father other (specify): _____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

Are there other adults who have a **significant** part in raising your child? Yes No
If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.) _____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc) _____

What do you feel are your child's...
Strengths _____
Weaknesses _____
Briefly describe your concerns for your child. _____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: biological child adopted child foster child other: _____
Mother's age at birth? _____ Did mother receive routine medical prenatal care? Yes No
Please specify any medications used during pregnancy and the reason used: _____

Pregnancy lasted _____ weeks / months Child's birth weight: _____ pounds _____ ounces
APGAR score ...at 1 minute _____ ...at 5 minutes _____ Unsure / Don't know
Did child go home from the hospital at the same time as the mother? Yes No
If No, explain why: _____

Please check the conditions below that describe the health of the child and mother during...

<u>Mothers pregnancy</u>	<u>Child's Delivery</u>	<u>Child's Condition at Birth</u>
<input type="checkbox"/> No complications	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Induced labor	<input type="checkbox"/> Lack of oxygen
<input type="checkbox"/> Falls	<input type="checkbox"/> C-section	<input type="checkbox"/> Breathing problem
<input type="checkbox"/> Physical injury	<input type="checkbox"/> Breech birth	<input type="checkbox"/> Birth injury/defect
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Unusually long labor (>12 hours)	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Premature # of weeks	<input type="checkbox"/> Newborn ICU # of days
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overdue # of weeks	<input type="checkbox"/> Other problem
<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Other problem (specify)	(specify)
<input type="checkbox"/> Toxemia		
<input type="checkbox"/> Alcohol and/or drug use		
<input type="checkbox"/> Use of tobacco		

B. Health

Describe the state of your child's current health: Excellent Good Fair Poor

Is your child currently taking any medication? Yes No

If yes, please list medications and uses: _____

Has your child ever been identified as having a disability? Yes No

If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? Yes No

If so, by whom (professional/agency) and when: _____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? Yes No

If so, by whom (professional/agency) and when: _____

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? Yes No

If so, by whom (professional/agency) and when: _____

Has your child ever participated in an early intervention program? Yes No

If so, by whom (professional/agency) and when: _____

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
<input type="checkbox"/> Serious Illnesses	
<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Surgery/Hospitalization	
<input type="checkbox"/> History of Ear Infections	
<input type="checkbox"/> Allergies and/or Asthma	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Frequent Nightmares and/or Bedwetting	
<input type="checkbox"/> Other health problem	

Family History

Is there a <i>family history</i> for the following problems?	<i>Biological</i> family member with the history... (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
<input type="checkbox"/> Learning Difficulties (reading, math, writing, spelling)	
<input type="checkbox"/> Speech or Language problem (articulation, stuttering, etc.)	
<input type="checkbox"/> Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
<input type="checkbox"/> Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
<input type="checkbox"/> Intellectual Disability	
<input type="checkbox"/> School Failure (failing grades, dropout, etc)	
<input type="checkbox"/> Drug or Alcohol Addiction	

C. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

III. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree?

- | | |
|---|--|
| <input type="checkbox"/> Did not enjoy cuddling | <input type="checkbox"/> Difficult nursing |
| <input type="checkbox"/> Was not easily calmed by being held or being stroked | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Difficult to comfort | <input type="checkbox"/> Did not turn towards caregivers |
| <input type="checkbox"/> Colicky | <input type="checkbox"/> Did not respond to name |
| <input type="checkbox"/> Excessive irritability | <input type="checkbox"/> Did not respond to speech of caregivers |
| <input type="checkbox"/> Diminished sleep | <input type="checkbox"/> Fascination with certain objects |
| <input type="checkbox"/> Frequent head banging | <input type="checkbox"/> Constantly into everything |

* Please describe all checked items _____

B. Child's Early Temperament: (*Toddler through five years of age*)

Activity Level – How active has your child been from an early age? _____

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? _____

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? _____

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? _____

Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? _____

Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

Prior to age six, did your child have more difficulty than other children his/her age...

- | | |
|--|--|
| <input type="checkbox"/> Sitting still at meal time | <input type="checkbox"/> Staying focused on TV, movies, or video games |
| <input type="checkbox"/> Paying attention when read to | <input type="checkbox"/> Waiting for a turn to play |
| <input type="checkbox"/> Throwing a ball | <input type="checkbox"/> Knowing left and right |
| <input type="checkbox"/> Catching a ball | <input type="checkbox"/> Acting without thinking |
| <input type="checkbox"/> Buttoning and zipping | <input type="checkbox"/> Dressing self |
| <input type="checkbox"/> Holding a crayon or pencil | <input type="checkbox"/> Tying shoe laces |
| <input type="checkbox"/> Accidentally dropping things | <input type="checkbox"/> Accidentally knocking things over |

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- | | |
|---|--|
| <input type="checkbox"/> Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn | <input type="checkbox"/> Often depressed/irritable mood |
| <input type="checkbox"/> Talks excessively, interrupts often, doesn't listen | <input type="checkbox"/> Often loses things, very disorganized compared to others his/her age. |
| <input type="checkbox"/> Low energy/fatigue | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Feeling of worthlessness or low self-esteem |
| <input type="checkbox"/> Difficulty initiating tasks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Difficulty completing tasks | <input type="checkbox"/> Overly anxious or fearful |
| <input type="checkbox"/> Difficulty following instructions | <input type="checkbox"/> Sleeping too little/insomnia |
| <input type="checkbox"/> Engages in impulsive behaviors (acts before thinking) | <input type="checkbox"/> Sleeping too much |
| <input type="checkbox"/> Immature compared to peers | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Engages in physically dangerous activities | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Often argumentative with adults | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Often actively defiant to adult requests and rules | <input type="checkbox"/> Rapid mood changes/mood swings |
| <input type="checkbox"/> Blames others for own mistakes | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Often angry or resentful | <input type="checkbox"/> Excessive need for reassurance |
| <input type="checkbox"/> Somatic complaints of not feeling well | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive separation difficulties | <input type="checkbox"/> Overeats |
| <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Explosive temper with minimal provocation |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Odd fascinations |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Unrealistic worry about futures events |
| <input type="checkbox"/> Aggressive towards others | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Adults | <input type="checkbox"/> Drug |
| <input type="checkbox"/> Peers | <input type="checkbox"/> Alcohol |
| | <input type="checkbox"/> other |

Please explain all checked items: _____

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When eating at the dinner table	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When playing by him/herself	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When playing with siblings/other children	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When with a babysitter or daycare	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
In public places (church, store)	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When in the car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When told to do something he/she doesn't want to do	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
During sit-down homework time	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When watching TV or playing video games	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

How would you describe your child's personality at home? _____

How does your child get along with brothers/sisters? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.) _____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's... Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? __Yes __ No

How much time does your child typically spend on electronic media? _____

Watching T V: ____hrs/day; Playing video/computer games: ____hrs/day; Other: _____ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No

Explain: _____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) _____

How does your child interact with children in the neighborhood? _____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? Not a struggle Sometimes a struggle Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? Yes No

If yes, what services, when did they begin? _____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare _____

Elementary School _____

Middle School _____

High School _____
