BOONE CLINTON JOINT SERVICES

SOCIAL AND DEVELOPMENTAL HISTORY FORM

Student Name: _____ □ Male □ Female
First Middle Last
School Attending: _____ Grade _____ Date of Birth_____

Guardians' Names: _____

Current Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Guardian's Email: _____

FAMILY HISTORY

Legal Guardianship:

□ Biological Mother
□ Biological Father
□ Step-father
□ Step-mother
□ Adoptive Mother
□ Adoptive Father
□ Foster Family
□ Guardian (specify): _____

Marital Status of Parents

□ Married
□ Single
□ Married but living apart
□ Other _____
□ Divorced (Check custodial status)
□ Joint Custody
□ Sole Custody (Which parent?) _____
□ Yes □ No Does the child have visitation with non-custodial parent?

Please list the names and ages of all people currently living at your child's residence:

Name	Relationship to Child	Age	Highest Grade Achieved

MEDICAL HISTORY

Describe any complications, medications, or other concerns experienced during the pregnancy (e.g., gestational diabetes, high blood pressure, preeclampsia, toxemia, etc) _____

At the time of birth/delivery:

Was the child full term? □ Yes □ No Duration of Pregnancy: _____
Cesarean section? □ Yes □ No Birth Weight: _____
Please describe any birth or delivery complications: _____

List any serious illnesses, injuries, hospitalizations, surgeries, or traumatic events (e.g., diabetes, seizures, convulsions, concussions, asthma, allergies, etc.)	Child's Age at the Time

Current Medical Diagnosis	Medical Provider's Name	Date of Diagnosis	Prescribed Medication

****Please attach any pertinent physician reports or diagnostic statements***

Does the child have a family history (biological parents, siblings, grandparents, aunts, uncles, cousins) of any of the following?

- □ Learning difficulties (reading, spelling, writing, math, organization)
- □ Speech or language difficulties (articulation, stuttering, organizing/recalling words, etc.)
- □ Emotional difficulties (depression, anxiety, mood disorder, psychosis, etc.)
- □ Cognitive difficulties (may have been called mental retardation or mental handicap)
- □ Genetic medical conditions impacting developmental, learning, and emotional health
- □ Abuses or domestic violence
- □ Substance abuse (drugs or alcohol)
- □ Other: _____

Does your child experience any of the following:

Vision problems?	□ Yes □ No	Glasses? □ Yes □ No Contacts? □ Yes □ No Date of recent vision exam _____ Results _____ Describe any vision sensitivity: _____
Hearing problems?	□ Yes □ No	Age detected: _____ Tubes in ears? □ Yes □ No Date: _____ Hearing aids? □ Yes □ No Cochlear implant? □ Yes □ No Date of recent hearing exam _____ Results _____ Describe any hearing sensitivity: _____
Sleep problems?	□ Yes □ No	Describe: _____
Taste problems?	□ Yes □ No	Describe: _____
Touch problems?	□ Yes □ No	Describe: _____

Other: _____

What is your child's primary language? _____What other languages are spoken at home? _____

Did the child demonstrate the following behaviors within an age-appropriate time line?

Behavior	Normal Age Range	
Rolled over	4-6 months	□ Yes □ No □ Don't know/Not yet shown
Sat alone	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Crawled	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Stood alone	12-15 months	□ Yes □ No □ Don't know/Not yet shown
Walked alone	12-15 months	□ Yes □ No □ Don't know/Not yet shown
Babbled	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Spoke first word	9-12 months	□ Yes □ No □ Don't know/Not yet shown
Combined words together	18-24 months	□ Yes □ No □ Don't know/Not yet shown
Toilet trained during the day	22-24 months	□ Yes □ No □ Don't know/Not yet shown

Please check early intervention services received when your child was a toddler: □ Speech and Language □ Developmental Therapy □ Physical Therapy □ Occupational Therapy □ Behavioral Therapy

□ Other: _____

SCHOOL HISTORY

Daycare/Preschool/School Attended	Date of Attendance

If your child repeated a grade, what grade was repeated? _____ School: _____
Reason for retention? _____

Has your child received private interventions or evaluations to assist with school progress?
 Educational services from private entity (e.g., private tutor, Sylvan, Learning Rx, Lindamood Bell, etc.)
 Therapy services from private entity (e.g., speech, occupational therapy, physical therapy, vision therapy, behavioral therapy, etc.)
 Private evaluations/previous school evaluations (***please attach previous educational reports***)

Please describe the following:
Your child's school strengths: _____
Your child's school weaknesses: _____
Your child's study habits at home: _____
Your child's attitude toward school: _____

BEHAVIORAL HISTORY

Please check behaviors deemed to be a **significant** concern at this time:

 Fidgets, is easily distracted,
 Has a hard time staying seated
 Shifts quickly from one activity to another
 Poor concentration
 Difficulty following instructions
 Difficulty playing quietly
 Engages in impulsive behavior
 Immature compared to peers
 Depressed/sad mood
 Sleeping too little
 Low energy/fatigue
 Excessive separation difficulties
 Overly anxious or fearful
 Temper tantrums
 Rapid mood changes/mood swings
 Defies adult requests and rules
 Deliberately annoys others
 Angry/resentful
 Poor appetite
 Often complains about bodily aches
 Often is truant or late
 Lies
 Substance abuse: drugs alcohol
 Stereotyped mannerisms
 Atypical/unusual fascinations or thoughts
 Fire setting
 Destroys others' property
 Talks excessively, interrupts often, doesn't listen
 Often loses things, very disorganized
 Has difficulty waiting his/her turn or in line
 Difficulty initiating tasks
 Difficulty completing tasks
 Often is loud
 Engages in physically dangerous activities
 Difficulty making decisions
 Feelings of worthlessness or low self-esteem
 Sleeping too much
 Repeatedly has nightmare/night terrors
 Shy/withdrawn
 Cries easily
 Argumentative with: adults peers
 Suicidal thoughts/acts
 Blames others for mistakes
 Physically aggressive towards: peers adults
 Easily frustrated
 Overeats
 Excessive worry about: events others
 Excessive need for reassurance
 Steals
 Often swears or uses obscene language
 Compulsive rituals
 Hallucinations: Visual Auditory
 Self-mutilation/self-injury
 Harms animals

Does your child display any of the atypical behavioral patterns?

- □ Preoccupation with specific topics or objects
- □ Not understand or aware of others' views
- □ Desires things to be in a specific way and routine
- □ Trouble understanding jokes and humor
- □ Difficulty adjusting to changes in plans/routines
- □ Eccentric forms of behavior
- □ Atypical facial or emotion responses to situations
- □ Unusual mannerisms and ways to move body
- □ Difficulty adjusting to new surroundings
- □ Other: _____

Please indicate and specify reasons your child received the following:

- □ Counseling _____
- □ Department of Children's Services _____
- □ Juvenile court or probation _____
- □ Mental health hospitalization _____
- □ Psychological evaluation _____

**** Please attach relevant reports.***

SOCIAL HISTORY

How does your child get along with adults at home?

_____

How does your child get along with siblings in the home?

_____

How does your child get along with peers?

_____

How many friends does your child have? _____ What activities does your child do with his/her friends?

_____

What are your child's favorite activities?

_____

What are your child's behavioral and social strengths?

_____

What are your child's behavioral and social weaknesses?

_____

Please indicate which occurred during the past year:

- □ Relocation to new city
- □ Loss of family member
- □ Change in family income
- □ New addition to the family
- □ New home
- □ Illness of family member
- □ Job change/loss
- □ Other (specify):

Other information you believe may be relevant to in the evaluation of your child:

_____

_____

_____

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