PSYCHOLOGICAL & SCHOOL SERVICES OF EASTERN CAROLINA

SOCIAL DEVELOPMENTAL HISTORY

Date_____

Student's Name_____DOB_____Grade_____

Race_____Age_____Sex_____School_____Teacher's Name_____

Home Address_____Phone Number_____

Name of Person Completing this form_____Relationship to Student_____

Family Information

Primary Language spoken at home by parents/guardians_____by student_____

Mother's Primary Language_____Father's Primary Language_____

Biological Mother's Name_____Biological Father's Name_____

Step-parent's Name (if applicable)_____

Mother's Education Background and Occupation_____

Father's Education Background and Occupation_____

List all members of the household_____

_____

Developmental History

Please specify by months (ie: 18 months, 12 months)

Sat Alone_____ Crawled_____ Walked alone_____ Toilet Trained_____

Fed Self_____ Dressed self_____ Spoke first words_____

Followed simple directions_____ Spoke sentences_____

Concerns about child's development_____

Health History

Date of last physical exam_____ Last Dental Exam_____

Circle YES OR NO

Frequent Colds	YES	NO	High Temperatures	YES	NO
Frequent Stomach Aches	YES	NO	Meningitis	YES	NO

Frequent Headaches	YES	NO	Childhood Diseases	YES	NO
Frequent Ear Infections	YES	NO	Poor Diet	YES	NO
Ear Infections started when:			Head Injures	YES	NO
Accidents (car, falls, etc)	YES	NO	Lost Consciousness	YES	NO
Fractures/Broken Bones	YES	NO	How Long??		
Constipation/Diarrhea	YES	NO	Pneumonia/Bronchitis	YES	NO

If Yes, please explain in detail_____

Circle YES OR NO

Vision Problems	YES	NO	Allergies	YES	NO
Wears Glasses	YES	NO	Asthma	YES	NO
Hearing Problems	YES	NO	Seizures	YES	NO
Migraine Headaches	YES	NO	Heart Problems	YES	NO
Physical abnormalities	YES	NO	Kidney Problems	YES	NO
Alcohol or drug use	YES	NO	Hyperactivity	YES	NO
Toileting accidents:			Sleeping Problems	YES	NO
Wetting (circle one)	Day	Night	Serious Illnesses	YES	NO
Soiling (circle one)	Day	Night	Genetic Disorder	YES	NO

If Yes, please explain in detail_____

Prenatal and Early Developmental History

Was the mother under a doctor's care during pregnancy?_____

Number of previous pregnancies and miscarriages_____

Check any of the following complications that occurred during pregnancy. Explain where needed.

Difficulty in conception	Toxemia	Abnormal weight gain
Measles	Excessive vomiting	German Measles
Excessive swelling	Emotional Problems	Vaginal Bleeding
Flu	Anemia	High Blood Pressure
Maternal injury--		
Hospitalization during pregnancy--		
X-rays during pregnancy--		
Medications used during pregnancy--		
Alcohol used during pregnancy--		
Cigarettes used during pregnancy--		
Other drugs used during pregnancy--		

Birth

Mother's age at birth_____ Birth Weight_____ Length of stay in hospital_____

Please circle YES or NO

Premature delivery	YES	NO	Birth Injuries	YES	NO
Late delivery	YES	NO	Lack of oxygen during birth	YES	NO
Induced labor	YES	NO	Baby required blood transfusion	YES	NO
Difficult/long labor	YES	NO	Birth Defects	YES	NO
Forceps delivery	YES	NO	Born with cord around neck	YES	NO
Cesarean birth	YES	NO	Incubator	YES	NO

If YES, please explain_____

_____

Neonatal (Birth to 6 months)

Jaundice (Bilirubin light, yellow skin)	YES	NO	Difficulty gaining weight	YES	NO
Seizures	YES	NO	Problem feeding and sucking	YES	NO
Anemia	YES	NO	Fussy, excessive crying	YES	NO

If YES, please explain_____

_____

Hospitalization

Explain any of the below if applicable.

Surgeries
Illnesses
Head Injury
Emergency Room Visits

Is your child on any medications? YES NO What?_____

Has your child ever been on long term medication (more than 6 months)? YES or NO

If yes, what?_____

Pediatrician and Specialty Physicians: _____

Educational Background

Please list all schools your child has attended, including preschool.

Has your child repeated any grades?_____If so, what grades?_____

Has your child skipped any grades?_____If so, what grades?_____

Has your child ever been evaluated for special education in the past? YES or NO If so, for what?_____

Has your child ever been evaluated for special education and not qualified? YES or NO If so, what school/city/state?_____

Does your child have a history of behavior problems at school?_____

Any other comments regarding school?_____

Social and Behavior Checklist

Check YES or NO

Difficulty communicating	YES	NO	Prefers to be alone	YES	NO
Does not get along with siblings	YES	NO	Is aggressive	YES	NO
Sucks thumb	YES	NO	Is timid or shy	YES	NO
Has frequent tantrums	YES	NO	Is more interested in things than ppl	YES	NO
Engages in behavior that could be dangerous to Self or others	YES	NO	Has special fears, habit or mannerisms	YES	NO
Rocks back and forth	YES	NO	Has frequent nightmares	YES	NO
Holds breath	YES	NO	Bangs head	YES	NO
Is stubborn	YES	NO	Eats poorly	YES	NO
Has blank spells	YES	NO	Is clumsy	YES	NO
Gives up easily	YES	NO	Is impulsive	YES	NO
Difficulty getting along with parents	YES	NO	Shows daredevil behaviors	YES	NO
Demonstrates repetitive behavior	YES	NO	Difficulty with transitions	YES	NO
Sleep alone in own bed	YES	NO	Uses bathroom independently	YES	NO
Is suicidal or homicidal	YES	NO	Self-esteem issues	YES	NO
Experiences hallucinations	YES	NO	Is depressed or sad	YES	NO
Is lethargic or has decreased energy	YES	NO	Is paranoid	YES	NO

Please check if any of your child's relatives have had any of the following:

YES		Relationship to child
	Alcohol or drug use	
	Tobacco Use	
	Anxiety disorder	
	Attention Deficit, Hyperactivity Disorder (ADHD)	
	Autism Spectrum Disorder or Asperger's Disorder (circle one)	
	Behavior problems	
	Bipolar disorder (manic depression)	

	Depression	
	Learning problems or Learning Disability (circle one)	
	Mental Retardation	
	Mood Disorder	
	Schizophrenia	
	Panic Attacks	
	Obsessive Compulsive Disorder	
	Tic Disorder	
	Alzheimer's or Dementia (circle one)	
	OTHER (please list):	

Please check any significant event which might have affected your child:

	Divorce		Physical Abuse
	Separation from the family		Sexual Abuse
	Neglect		Emotional Abuse
	Death of Family, Friend, Pet		Domestic Violence Witnessed
	Extensive Bullying		Natural Disaster or Fire

If checked, please explain_____

_____

Please explain your child's temperament or personality._____

_____

Please list your child's strengths._____

_____

Please list your child's weaknesses._____

_____

Please share any other thoughts or concern that would be helpful to us._____

_____

What else is important for me to know about your child?:

_____

_____

Please state what you hope to get out of the testing/therapy results: _____

_____