

East Central Center for Exceptional Children
16 South 8th St
New Rockford, ND 58356

Social Medical History

Child's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Grade: _____

Home School: _____ Servicing School: _____

Name and Age of Brothers and Sisters: _____

Parents: Mother: _____ Father: _____

Please Check: Biological _____ Adoptive _____ Foster _____ Guardian _____ Other _____

Address City, State, Zip

Telephone: Home: _____ Work: _____

Signature of Person Completing Form

Date

BIRTH HISTORY

Age of Father at time of child's birth: _____ Age of Mother at time of child's birth: _____

Child's birth weight: _____

Describe any unusual illnesses or conditions during Mother's pregnancy:

Describe any unusual labor problems or difficulties:

Describe any problems or difficulties baby had at delivery:

GROWTH AND DEVELOPMENT

Please rate your child's motor development:

(1)	(2)	(3)	(4)	(5)
below average		(average)		(above average)

Please rate your child's growth:

(1)	(2)	(3)	(4)	(5)
below average		(average)		(above average)

Please describe any problems you feel your child has with coordination:

Please describe any history of speech/language problems in your family:

Please describe your child's ability to express his/her thoughts:

Please describe your child's attention: (ex. Following directions, listening to stories, watching television:

HEARING

Does your child respond to sounds/voices _____

Does your child understand what is said to him/her _____

Does your child often ask you to repeat what you have said _____

Has your child's hearing ever been checked _____

Please describe any history of hearing problems in the family:

VISION

Does your child:

Blink frequently _____

Rub eyes frequently _____

Squint _____

Has your child's vision ever been checked: _____

Does your child wear glasses _____

Please describe any history of vision problems in the family:

PERSONAL CARE

Please describe any difficulties your child has with:

Eating: _____

Dressing: _____

Bowel/Bladder Control: _____

BEHAVIORAL, EDUCATION AND SOCIAL SKILLS

List some interests of your child (hobbies, sports etc.): _____

How does your child respond when under stress: _____

Please describe any problems you feel your child has with behavior:

What age group does your child relate to most of the time: _____

Do you think your child has a learning problem: _____ If yes, please describe:

If your child is of school age, rate your child's performance in school:

(1)	(2)	(3)	(4)	(5)
below average		(average)		(above average)

Comments: _____

MEDICAL HISTORY

Please check the items that apply to your child and add comments as you feel necessary:

Recent physical examination _____

Family physician _____

Neurological examination: _____

Serious illness _____

Surgery _____

Long term medication _____

Frequent ear infections _____

Physical limitations _____

Allergies _____

Other _____

Please feel free to state any questions, comments or concerns you may have in the space below.