John Glenn School Corporation
Special Education Department
INITIAL SOCIAL AND DEVELOPMENTAL HISTORY

Child's Name _____ Birthdate_____ Age_____
School _____ Grade _____ Sex: _____Male _____Female
Home Address_____

Phone _____ Email _____

Ethnic Background (Circle one): American Indian or Native Alaskan, Asian or Pacific Islander, Hispanic, Black American, White (not Hispanic), Multiracial

Person completing this form: (Circle one): Natural Mother, Natural Father, Foster Parent, Stepmother, Stepfather, Adoptive Parent or Other (Please explain):_____
Date Form Completed _____ Date Form Received by School Psychologist _____

Marital status of parents: _____

If separated or divorced, how old was child at separation _____ at divorce _____

Who has custody of this child? _____ Does the child have contact with the non-custodial parent? _____

How often does the non-custodial parent see this child? (Circle one): At least Weekly, Monthly, Few times each Year, or Never

Is either biological parent deceased? Mother _____ Father _____ If Yes, indicate the year _____

Mother's Name _____ Age _____ Education _____
Occupation_____ Phone: Home_____ Business_____
Father's Name _____ Age_____ Education _____
Occupation_____ Phone: Home_____ Business_____
Stepmother's Name _____ Age_____ Education _____
Occupation_____ Phone: Home_____ Business_____
Stepfather's Name _____ Age_____ Education _____
Occupation_____ Phone: Home_____ Business_____

List all brothers and sisters, or others living with the family and their relationship to the child.

Name	Age	Sex	Relationship to child	Living in home?	Living outside home?

Describe the child's relationship with siblings or others in home. _____

_____

Has the student been involved in any of the following settings? If yes, indicate the dates: Foster home _____

Group home _____ Correctional Facility _____ Psychiatric Facility _____ Other (specify) _____

Primary language spoken in the home:_____ Other languages spoken in the home: _____

Child's Name:_____

STUDENT'S PRESENT PERFORMANCE

List your child's strengths: _____

_____

_____

List your child's interests: _____

_____

_____

Briefly describe your child's current difficulties: _____

_____

_____

How long has this problem been of concern to you? _____Are there other family members with the same problems? _____

If Yes, list name and relation:_____

Has the child received evaluation or help for the current problem or similar problems? Yes_____ No_____

If Yes, list when and with whom _____

MEDICAL HISTORY

Is the child on any medication at this time? Yes _____ No _____. If Yes, list information.

Medication	Dosage	Dispensed at Home	Dispensed at School	Diagnosis and Reason for Medication

Check all illness or condition(s) that your child has had:

_____Cancer	Age_____	_____Allergies	Age_____	_____Encephalitis	Age_____
_____Hospitalization	Age_____	_____High Fever	Age_____	_____Frequent or Severe Headaches	Age_____
_____Head injury	Age_____	_____Asthma	Age_____	_____Unconsciousness	Age_____
_____Operations or Surgery	Age_____	_____Diabetes	Age_____	_____Seizure Activity	Age_____
_____Meningitis	Age_____	_____Dizziness	Age_____	_____Attention Deficit Disorder	Age_____
_____Bone/Joint Disease	Age_____	_____Broken Bones	Age_____	_____Wetting or Soiling Day _____Night _____	Age_____
_____Sleeping Problems	Age_____	_____Suicide Attempt	Age_____	_____Lead Poisoning	Age_____
_____Color Blindness	Age_____	_____Other (Specify) _____			Age _____

Other chronic medical conditions:_____

_____

Please further explain any listed illness or condition:_____

_____

Name of Child's Doctor _____ Address _____

Date of last Physician examination _____ Does the Physician know of the child's school problems? _____

Physician's comments about school problems:_____

_____

Child's Name: _____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any family member has had. When you check an item, list the family member's relationship to the child.

- □ Academic Problems _____
- □ Alcoholism _____
- □ Cancer _____
- □ Depression _____
- □ Developmental Problems _____
- □ Diabetes _____
- □ Drug Problems _____
- □ Emotional Problem _____
- □ Epilepsy _____
- □ Heart Trouble _____
- □ Neurological Disease _____
- □ Suicide Attempt _____
- □ Other Medical Issues _____

DEVELOPMENTAL FACTORS

PREGNANCY: Mark if mother had any of the following during pregnancy:

_____Hospitalizations
_____Convulsions
_____German Measles
_____Diabetes
_____High Fever
_____Medications (specify): _____
_____Infectious Diseases (List) _____
_____Exposure to X-rays or Chemicals

IS THERE A PRENATAL HISTORY OF MOTHER USING (indicate which trimester)

Cigarettes 1st ___ 2nd ___ 3rd ___ Alcohol 1st ___ 2nd ___ 3rd ___ Recreational Drugs 1st ___ 2nd ___ 3rd

When did the Mother have physician care during pregnancy? 1st ___ 2nd ___ 3rd ___ Prescription or other Drugs 1st ___ 2nd ___ 3rd ___

BIRTH FACTORS:

Length of pregnancy: _____ Weight at birth: _____ Was a caesarean (C-section) performed? ___

Prolonged, difficult or forced labor? _____ Birth defects or complications: ____

Were there any special problems within the first month? _____

EARLY DEVELOPMENT: At what age did the child do the following:

Sit alone _____ Speak first words _____ Speak in Sentences (2 – 3 words) _____

Crawl _____ Walk alone _____ Have Bladder and Bowel Control _____

Did the doctor indicate any developmental problems during the child's first three years of life? Yes _____

No_____ If Yes, please explain._____

SPECIAL FACTORS

VISION:
____No apparent problem
____Vision Examination
date _____by whom_____
____Wears glasses
____Wears contacts
____Had surgery (specify:_____age_____)

HEARING:
____No apparent problem
____Hearing Examination
date _____by whom_____
____Had surgery (specify _____age_____)
____Ear infections/frequency_____
____Hearing loss/Age of loss_____

GROSS AND FINE MOTOR:
____No apparent problem
____OT or PT Examination
date _____by whom_____
____Walking, jumping, running problems
____Cutting, writing, coloring printing problems

COMMUNICATION:
____No apparent problem
____Speech and Language Examination
date _____by whom_____
____Problems expressing thoughts
____Problems pronouncing words

____Other (specify _____) ____Other (specify _____)

SOCIAL:

How does your child interact with other children? (list any: fights, play groups, friends, trouble, etc.) _____

How does your child get along with adults? _____

Have you noticed any unusual social interactions? Yes_____No_____ If Yes, please explain: _____

SCHOOL HISTORY

Preschool/Grade Level	Name of School	Location

Has your child been absent from school a lot? Yes _____ No _____ If Yes, please explain: _____

SCHOOL INTERVENTIONS

MARK INTERVENTIONS THE CHILD HAS RECEIVED:	YES	NO	GRADES	COMMENTS
Repeated Grade				
Reading Assistance				
Remediation				
Speech/Language Services				
Counseling or Social Services				
Suspension or Expulsion				
Summer School				
Other (specify)				

Child's Name:_____

AGENCY SERVICES

LIST THE AGENCIES THAT HAVE PROVIDED SERVICES FOR THE CHILD:	DATES	REASON (Provide as much detail as possible; use a separate page if necessary)
Private Tutoring		
Private Counselor or Therapist (specify)		
Community Service Agency (specify)		
Mental Health Agency		
Department of Children and Families		
Court System		
Day Treatment Program (specify)		
Inpatient Psychiatric Hospital (specify)		

What do you think your child needs to do that he/she is not doing now and why?

_____

_____

_____

Do you have any other questions or concerns? _____

_____

_____

Any other information which would help us understand your child?

_____

_____

_____

_____