COUNCIL ROCK PRIMARY SCHOOL

SOCIAL AND DEVELOPMENTAL HISTORY

(CONFIDENTIAL)

Name of Child: _____Date of Birth:_____

Date: _____ Form completed by: _____

Parent/Guardian:_____

Relationship to student:_____ Occupation:_____

Parent/Guardian:_____

Relationship to student:_____ Occupation:_____

Step Parent/Guardian:_____
(Living in the student's main residence)
Occupation:_____

Describe Current Family Structure: ex: 2 natural parents, 2 parents (step), single parent, guardian, foster home

_____

Siblings or others living in the home (first and last names)	**Age**	**Relationship**	**Living at home?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other language(s) spoken at home:_____

Is the child proficient in this language? _____yes _____no

Is the child able to read/write it? _____yes _____no

Custodial Arrangements: (separated or divorced parents)

____ Sole custody with _____
(specify)

____ Joint custody

____ Custody agreement submitted to school

____ Other

Developmental Milestones:

Did your child develop normally? _____yes _____no

Please indicate when these milestones occurred (approximately)

First walked _____months

First word _____months

Spoke in sentences _____years

Established hand preference clearly _____years

Fine motor skills _____years (writing/copying)

Articulation difficulties? _____yes _____no

Does your child use the toilet independently? _____yes _____no

Does your child separate from your easily? _____yes _____no

Do you have any concerns about your child's activity level? _____yes _____no

Medical Background:

Date of child's last physical exam: _____ Notable findings: _____

_____

Check those that pertain to your child:

___Medical/physical disability
___Convulsions/seizures
___Attention Deficit Hyperactivity
___Disorder
___Serious accident/trauma/surgery
___Normal childhood illnesses
___Asthma
___Tubes in ears
___Allergies (type)_____
___Frequent ear infections
___Hearing problems
___Diabetes
___Sleep problems/nightmares
___High fevers
___Bedwetting/soiling during the day
___Autism

Does your child regularly take any medication? ____yes ____no

If yes, state name, dosage and reason for taking medication._____

_____

Physician's name that prescribed this medication:_____

Did you ever suspect that your child could not see well? _____yes _____no

Please describe concern:

_____

Has your child's vision been checked? ____yes____no Glasses? ____yes ____no

Did you ever suspect that your child could not hear well? ____yes ____no

Has your child been screened for a hearing loss? ____yes ____no

Child's Name _____

School History:

Did your child attend preschool and/or day care?___yes __no How many years? _____

Name of preschool/day care _____

Previous school experience (K-2):

Grades:	Name of School:	Dates:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child's entrance to kindergarten been delayed? ____yes ____no

Has your child ever repeated a grade? ____yes ____no Which grade? _____

At which schools? _____

Does your child have a history of difficulty with school? ____yes ____no

Please describe your child's school performance and behavior: _____

_____

_____

Are there learning, behavioral, medical or mental health issues with other family members? _____

_____

Has your child ever received counseling, therapy or other mental health services from an agency, private therapist, etc: ____yes ____no

Have there been any major changes in your child's life? ____yes ____no

If yes, describe_____

Describe your child's current personality/interests:_____

_____

_____

In what tasks, responsibilities, skills, etc is your child most successful? _____

_____

_____

How does your child enjoy spending his/her play/free time?_____

_____

_____

Describe your child's peer relationships? (for example: shy/outgoing, leader/follower, trouble making/keeping friends, prefers older/younger/same age, withdrawn/aggressive)

_____

_____

Describe your child's sibling relationships: _____

_____

How is your child disciplined at home? _____

_____

How does your child react to discipline?:_____

_____

Is there any other important information that will help us work with you and your child?

_____

_____

Do you wish to speak to someone about any of your child's needs? ____yes _____no