Sociological and Developmental History Information

Educationally Relevant Medical, Development, and Family Information
This information may be included in a confidential psycho-educational evaluation report.

Student Information:

Student Name:____DOB: ____/____/____
Grade:______________ Teacher:____
School:____

Parent(s)/Guardian:____

Are biological parents of child currently: ☐ married ☐ separated ☐ divorced ☐ never married

• If separated or divorced, who has *legal* custody? ☐ mother ☐ father ☐ other (specify): _______________
____

II. Family Information:

Is your child: ☐ biological child ☐ adopted child ☐ foster child ☐ other: ___________________________

Who does child live with: ☐ both parents ☐ mother ☐ father ☐ other (specify) ______________________

Biological father______________________ Occupation_____________ Years education: _______________

Biological mother_____________________ Occupation_____________ Years education: _______________

Please list all people in child's immediate family:____
____

Name Relationship to child Age / Grade Living in house?____
____

Are there other adults who have a ***significant*** part in raising your child? ☐ Yes ☐ No

If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)______________
____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)____
____

Is there any other major life event experienced by your child that you think may have had an impact on your child?
____

What are your child's strengths?
____
____

What concerns do you have for your child? ____
____

In what language did your child first learn to talk?
____

If English is 2nd language, how long has your child spoken English?

____

What language is primarily spoken at home?

____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace ____ Moved at age_____grade__________

2. ____ Moved at age_____grade__________

3. ____ Moved at age_____grade__________

4. ____ Moved at age______grade__________

III. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Mother's age at birth? ________ Did mother receive routine medical prenatal care? ☐ Yes ☐ No

Please specify any medications used during pregnancy and the reason used: __________________________

____

Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ ☐ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? ☐ Yes ☐ No

If No, explain why:____

____

Has your child ever participated in an early intervention program or early childhood special education program? ☐ Yes ☐ No

If so, by whom (professional/agency) and when: ______________________________________

____

Please check the conditions below that describe the health of the child and mother during…

✓	**Mothers pregnancy**	✓	**Child's Delivery**	✓	**Child's Condition at Birth**
	No complications		Normal		Normal
	Blackouts		Induced labor		Lack of oxygen
	Falls		C-section		Breathing problem
	Physical injury		Breech birth		Birth injury/defect
	Excessive bleeding		Unusually long labor (>12 hours)		Jaundice
	Hypertension		Premature # of weeks?		Newborn ICU # of days?
	Diabetes		Overdue # of weeks?		Other problem (specify:)
	Emotional stress		Other problem (specify):		
	Toxemia				
	Alcohol and/or drug use				
	Use of tobacco				

B. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

C. Health

Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list medications and uses: ____

____

Has your child ever received psychological counseling? ☐ Yes ☐ No

If so, by whom (professional/agency) and when: ____

____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? ☐ Yes ☐ No

If so, by whom (professional/agency) and when: ____

____

Child's physician______________________________ Physician phone #______________________

Has this child ever had any serious illnesses, accidents, or head injuries? _____ Yes ______ No

If "yes", please explain:____

Has this child ever experienced problems in the following areas?

	walking		sleep problems
	unclear speech		eating problems
	failure to thrive		temper tantrums
	Hearing		fine motor skills (handwriting, tying shoes)
	Vision		underweight/ overweight
	does not speak		gross motor skills (running, riding bike, skip)
	Other:		Difficulty making friends

If any of the above are checked please specify:

____
____

Please indicate any illness this child has experienced:

	Measles		Seizures
	Mumps		Loss of consciousness
	Asthma		Any heart condition
	Frequent Ear Infections		Allergies
	Gastro-intestinal problems		Rheumatic fever
	Meningitis		Diphtheria
	Verbal/ motor tics		Other:

Please describe any others:

____

IV. Educational Background:

Did this child attend preschool? _____ Yes _____ No

If "Yes", where and for how long?

____

Have any relatives had difficulties similar to those this child is experiencing? _____ Yes _____ No

If "Yes", please explain:

____

Please indicate any of the following that this student has experienced in school:

	Had frequent absences from school		Disliked going to school
	Behavior problems		Emotional difficulties
	Changed schools several times in one school year		Difficulty with Math
	Poor Grades		Has been evaluated for special education
	Been Retained		Difficulty with writing or spelling
	Difficulty with Reading		
	Skipped a grade		

Other:____

IV. Social History:

How does your child spend his/her free time?

____
____

How may close friends does your child have? _____ 0-2 _____ 2-4 _____ 4 or more

V. BEHAVIOR

Prior to age six, did your child have more difficulty than other children his/her age…

☐ Sitting still at meal time	☐ Staying focused on TV, movies, or video games
☐ Paying attention when read to	☐ Waiting for a turn to play
☐ Throwing a ball	☐ Knowing left and right
☐ Catching a ball	☐ Acting without thinking
☐ Buttoning and zipping	☐ Dressing self
☐ Holding a crayon or pencil	☐ Tying shoe laces
☐ Accidentally dropping things	☐ Accidentally knocking things over

Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn	☐ Often depressed/irritable mood
☐ Talks excessively, interrupts often, doesn't listen	☐ Often loses things, very disorganized compared to others his/her age.
☐ Low energy/fatigue	☐ Shy
☐ Poor concentration	☐ Feeling of worthlessness or low self-esteem
☐ Difficulty initiating tasks	☐ Withdrawn
☐ Difficulty completing tasks	☐ Overly anxious or fearful
☐ Difficulty following instructions	☐ Sleeping too little/insomnia
☐ Engages in impulsive behaviors (acts before thinking)	☐ Sleeping to much
☐ Immature compared to peers	☐ Difficulty making decisions
☐ Engages in physically dangerous activities	☐ Cries easily
☐ Often argumentative with adults	☐ Temper tantrums
☐ Often actively defiant to adult requests and rules	☐ Rapid mood changes/mood swings
☐ Blames others for own mistakes	☐ Suicidal thoughts
☐ Often angry or resentful	☐ Excessive need for reassurance
☐ Somatic complaints of not feeling well	☐ Poor appetite
☐ Excessive separation difficulties	☐ Overeats
☐ Easily frustrated	☐ Explosive temper with minimal provocation
☐ Lies	☐ Odd fascinations
☐ Steals	☐ Unrealistic worry about futures events
☐ Aggressive towards others o Adults o Peers	☐ Substance abuse o Drug o Alcohol o other

Please explain all checked items: ____
____
____
____
____

Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently
When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently
When watching TV or playing video games	☐ Rarely	☐ Sometimes	☐ Frequently

How would you describe your child's personality at home?____

____

How does your child get along with brothers/sisters? ____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)____

____

How does your child respond to discipline?____

List any responsibilities your child has at home: _______________________________________

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM

How much time does your child typically spend on electronic media? _____________________________

Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other:______________ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No

Explain:____

____

Name of person completing this form:_________________________ Date: _____________________________

Relationship to the student: ____

Please return this form to: Lynda Wingo at Wallowa ESD 107 SW First St. # 105, Enterprise, OR 97828

Please write down anything else about your child that may be important to this evaluation: