

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name _____ DOB _____ Age _____ Grade _____

Classroom teacher _____

Current Address: _____

How long at this address? _____

Person providing information: _____

Relationship to child _____

Who does child live with: _____

Parent _____ Occupation _____ Years education: _____

Parent's home phone _____ Work # _____ Cell # _____

Parent _____ Occupation _____ Years education: _____

Parent's home phone _____ Work # _____ Cell # _____

If applicable: Guardian's name _____ Occupation _____ Years education _____

Guardian's home phone _____ Work # _____ Cell # _____

Please list other parents or caregivers involved in child's life now or in the past:-

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

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

Please list all other *non-family* members who live in household: _____

Name Relationship to child/family How long has lived in household? _____

Language(s) spoken at home _____

Primary Language 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 _____

Are child's parents currently: married separated divorced never married cohabitating

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

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

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) _____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: biological child adopted child foster child other: _____

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: _____

Pregnancy lasted _____ weeks / months 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: _____

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

Mother's pregnancy

- No complications
- Blackouts
- Falls
- Physical injury
- Excessive bleeding
- Hypertension

- Diabetes
- Emotional stress
- Toxemia
- Alcohol and/or drug use
- Use of tobacco

Child's Delivery

- Normal
- Induced labor
- C-section
- Breech birth
- Unusually long labor (>12 hours)
- Premature # of weeks

- Overdue # of weeks
- Other problem (specify)

Child's Condition at Birth

- Normal
- Lack of oxygen
- Breathing problem
- Birth injury/defect
- Jaundice
- Newborn ICU # of days

- Other problem (specify)

B. 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 been identified as having a disability? Yes No

If so, by whom, what age, & what disability? _____

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: _____

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? Yes No

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

Has your child ever participated in an early intervention program? Yes No

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

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
<input type="checkbox"/> Serious Illnesses	
<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Surgery/Hospitalization	
<input type="checkbox"/> History of Ear Infections	
<input type="checkbox"/> Allergies and/or Asthma	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Frequent Nightmares and/or Bedwetting	
<input type="checkbox"/> Other health problem	

Family History

Is there a <i>family history</i> for the following problems?	Family member with the history... (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
<input type="checkbox"/> Learning Difficulties (reading, math, writing, spelling)	
<input type="checkbox"/> Speech or Language problem (articulation, stuttering, etc.)	
<input type="checkbox"/> Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
<input type="checkbox"/> Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
<input type="checkbox"/> Intellectual Disability	
<input type="checkbox"/> School Failure (failing grades, dropout, etc)	
<input type="checkbox"/> Drug or Alcohol Addiction	

C. 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								
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III. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree?

- Did not enjoy cuddling
- Was not easily calmed by being held or being stroked
- Difficult to comfort
- Colicky
- Excessive irritability
- Diminished sleep
- Frequent head banging
- Difficult nursing
- Poor eye contact
- Did not turn towards caregivers
- Did not respond to name
- Did not respond to speech of caregivers
- Fascination with certain objects
- Constantly into everything

* Please describe all checked items _____

B. Child's Early Temperament: (*Toddler through five years of age*)

Activity Level – How active has your child been from an early age? _____

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? _____

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? _____

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? _____

Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? _____

Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

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

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

C. Differential Behaviors

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

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

Please explain all checked items: _____

D. Home Behavior:

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

Getting ready for school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Eating at the dinner table	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Playing alone	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Playing with siblings/other children	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Being with a babysitter or at daycare	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Being in public places (church, store)	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Riding in the car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Being told to do something he/she/they doesn't want to do	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Doing homework time	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Watching TV or playing video games	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

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

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

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

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: _____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's... Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? __Yes __ No

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: _____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) _____

How does your child interact with children in the neighborhood? _____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? Not a struggle Sometimes a struggle Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? Yes No

If yes, what services, when did they begin? _____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare _____

Elementary School _____

Middle School _____

High School _____