"It takes a whole village to raise a child"

CONFIDENTIAL

Social & Developmental History Form for Parents

Today's Date: ______________________________

Student Name: ______________________________ Date of Birth: ______________

Filled Out By: ______________________________ Relationship: ______________

Please note: All information provided is confidential with restricted access at all times.

Current Family Structure (of child's main residence)

_______ intact 2-parent (natural) _______ intact 2-parent (step)

_______ single parent (mother) _______ single parent (father

_______ guardian _______ foster home _______ other

Biological **Father's** Name: ______________________________ Phone: ______________

Address (if different from student): ______________________________

Occupation: ______________________________ Highest Grade Completed: __________

Biological **Mother's** Name: ______________________________ Phone: ______________

Address (if different from student): ______________________________

Occupation: ______________________________ Highest Grade Completed: __________

Step Parent/Guardian Name: ______________________________

(living in student's main residence): ______________________________

Occupation: ______________________________ Highest Grade Completed: __________

Siblings: (Please note first and last name)	**Age:**	**Relationship:**	**Living at Home:**	**Attending MPTCS:**
Name(s) ____________	____	____________	________	________
Name(s) ____________	____	____________	________	________
Name(s) ____________	____	____________	________	________
Name(s) ____________	____	____________	________	________

marion p. thomas

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Are others living in the home? ______________________________

Has your child's living situation changed in the last three years? ______Yes ______No

If yes, please describe: ______________________________

Other language(s) spoken in the home: ______________________________

Is child proficient in this language? ______Yes ______No Is he/she able to write it? ______Yes ______No

Family History:

Is there a family history that you know of in either biological parent, brothers, sisters, grandparents, aunts, uncles, etc:

__________ Learning difficulties (reading, math, writing, spelling, organization)

__________ Speech or language problems (articulation, stuttering, organizing/recalling words, etc.)

__________ Emotional problems (depression, excessive anxiety, mood swings, psychosis, etc.)

__________ Mental retardation

__________ Seizure disorder (epilepsy)

__________ School failure

__________ Drug-alcohol addition

If yes, please describe further: ______________________________

____

Prenatal, Birth and Developmental Histories:

Was this pregnancy difficult? ______Yes ______No What was your child's birth weight: ______________

If above answered yes, please describe difficulty and treatment:

____

____

Any illness during pregnancy (type):

____

Any smoking: ______ Alcohol: ______ during pregnancy?

Was your child born at the expected time? ______Yes ______No How early/late was he/she? ___________

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Any illnesses/treatments during child's first year?

____

____

Developmental Milestones: Did child develop normally? ______Yes ______No

Please indicate whether or not these occurred at a normal pace:

First walked: _______months

Established hand preference clearly ______ years

First word: ______ months

Fine-motor skills ______ years (writing/copying)

Spoke in sentences ______ years

Articulation difficulties ______Yes ______No

Describe child's early temperament (for example: sensitive, irritable, stubborn, easy active, passive, excitable)

____

How is your child disciplined at home? ____

What is your child's bedtime routine? ____

Medical Background:

Date of child's last physical exam: __________ Any notable findings: ____________________

Please circle any that pertain to your child:

Convulsions/Seizures	Tubes in ears	Attention Deficit Hyperactivity Disorder
Serious accident/Trauma/Surgery	Diabetes	Elevated Lead Levels
Sleep Problems/Nightmares	Asthma	Normal childhood illnesses
Frequent ear infections	High fevers	Hearing problems
Bed wetting/soiling during day		Allergies (type) ____________

Please describe further any circled responses: _______________________________________

____

____

Does your child take any medication? ______Yes ______No If yes, state name, dosage and reason for taking medication:____

____

Physician prescribing this medication: ____

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Did you ever suspect that your child could not see well? ______Yes ______No

Has child ever been seen by optometrist or eye specialist? ______Yes ______No

Glasses/Contacts ______Yes ______No If, yes please describe concern: ______________________

____

Has your child ever received counseling, therapy or other mental health/drug treatment, etc. services from an agency, private therapist, etc.? ______Yes ______No

Nature of this service and duration: ____

____

School History:

Is this your child's first year in kindergarten? ______Yes ______No

If no, please advise where they attended school previously: ______________________________

____

Has your child ever been referred for Early Intervention Services and/or Child Study Team Services.

______Yes ______No

Thank you so much for your help in filling out and returning this very important form.