

**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		Diagnosis and Reason for Medication
		Home	School	

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: \_\_\_\_\_

**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.

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Problems _____      | <input type="checkbox"/> Emotional Problem _____    |
| <input type="checkbox"/> Alcoholism _____             | <input type="checkbox"/> Epilepsy _____             |
| <input type="checkbox"/> Cancer _____                 | <input type="checkbox"/> Heart Trouble _____        |
| <input type="checkbox"/> Depression _____             | <input type="checkbox"/> Neurological Disease _____ |
| <input type="checkbox"/> Developmental Problems _____ | <input type="checkbox"/> Suicide Attempt _____      |
| <input type="checkbox"/> Diabetes _____               | <input type="checkbox"/> Other Medical Issues _____ |
| <input type="checkbox"/> Drug Problems _____          |   |

**DEVELOPMENTAL FACTORS**

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

- |                        |                                    |  |
|------------------------|------------------------------------|--|
| _____ Hospitalizations | _____ Diabetes                     | _____ Infectious Diseases (List) _____ |
| _____ Convulsions      | _____ High Fever                   | _____ Exposure to X-rays or Chemicals  |
| _____ German Measles   | _____ Medications (specify): _____ |  |

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

- Cigarettes 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_      Alcohol 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_      Recreational Drugs 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_
- When did the Mother have physician care during pregnancy? 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_      Prescription or other Drugs 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_

**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

Child's Name: \_\_\_\_\_

\_\_\_\_ 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**

<u>Preschool/Grade Level</u>	<u>Name of School</u>	<u>Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

**SCHOOL INTERVENTIONS**

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

**AGENCY SERVICES**

<b>LIST THE AGENCIES THAT HAVE PROVIDED SERVICES FOR THE CHILD:</b>	<b>DATES</b>	<b>REASON (Provide as much detail as possible; use a separate page if necessary)</b>
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?

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Do you have any other questions or concerns? \_\_\_\_\_

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Any other information which would help us understand your child?

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