

YOUR RELATIONSHIP TO THIS CHILD: _____

MARITAL STATUS: S M D W

IS CHILD LIVING WITH BOTH PARENTS? _____ IF NOT, WHY? _____

WITH WHOM DOES CHILD RESIDE : _____

IS THERE ANY FURTHER INFORMATION SCHOOL SHOULD BE AWARE OF REGARDING FAMILY? _____

FATHER'S INFORMATION		MOTHER'S INFORMATION	
Name:		Name:	
Date of Birth:		Date of Birth:	
Place of Birth:		Place of Birth:	
Current Age:		Current Age:	
Marital Status:		Marital Status:	
Occupation:		Occupation:	
Business Phone:		Business Phone:	
Employer Address:		Employer Address:	
Years Employed:		Years Employed:	

Please list all other children in your family, starting with the oldest child.

Full Name	Sex	Age	Date of Birth	Grade	In/Out of Home	Full, half or step-sibling	Yes / No Living at Home

Please list all other people living with you and their relationship:

Name	Relationship	Name	Relationship

What kind of activities does your family enjoy doing together? _____

INDICATE WHICH OF THE FOLLOWING SPENDS SOME TIME REGULARLY CARING FOR THIS CHILD:

MOTHER: _____ GRANDMOTHER: _____ NEIGHBOR: _____ DAYCARE: _____

FATHER: _____ GRANDFATHER: _____ FRIEND: _____

OTHER RELATIVE (STATE RELATIONSHIP) _____

HAS CHILD'S HOME ALWAYS BEEN WITH YOU? YES _____ NO _____ (if 'NO', answer A and B)

A. How long has this child's home been with you? From _____ To _____

B. How long has this child lived in each of the following:

RELATIVE _____ From _____ To _____
Name

OTHER _____ Other _____ To _____
Name

ADDITIONAL INFORMATION REGARDING LIVING ARRANGEMENT:

PART II – CHILD'S BIRTH HISTORY

1. Did mother receive regular prenatal care? Yes _____ No _____

2. Mother's health during pregnancy: (Check all that apply)

☐ Toxemia? High blood pressure?

☐ RH incompatibility?

☐ Illnesses? (specify)

☐ Diabetes?

☐ Epilepsy?

☐ Any accidents/injuries?

☐ Prescribed medication (including vitamins, non-prescription medication, drugs)

Please list: _____

☐ Alcohol? (How often? _____ What kind? _____ How much _____)

☐ Cigarettes? (How many packs each day? _____)

☐ Recreational drugs? (How much? _____ What kind? _____)

3. Delivery (Please check all that apply)

☐Caesarian ☐Premature ☐Forceps ☐Breech ☐Full term ☐Traumatic or complicated delivery
Birth weight: _____ Apgar Score _____

Describe any health complications with infant at or following birth? _____

Describe any health complications with mother at or following birth? _____

How many days in the nursery before going home? _____

Was mother discharged from hospital prior to child? ☐ Yes ☐ No

PART III – INFANCY

1. Were there any early feeding problems? _____

2. Developmental Stages (list ages)

Sat alone unsupported _____

Babbled _____

Crawled _____

Spoke first word _____

Walked _____

Began to use two-word phrases _____

Compared to other children his/her age, was development

☐ faster ☐ slower ☐ normal

Are there other concerning areas of development that you have not already noted?

Was there ever any significant loss of skills, i.e., stopped talking? ☐ Yes ☐ No

BLADDER / BOWEL CONTROL

Age training was completed: Bowel _____ Bladder _____

Age when occasional accidents no longer occurred _____

Difficulties in toilet training? ☐ Yes ☐ No If 'Yes' explain: _____

PART IV – MEDICAL / HEALTH INFORMATION

1. Has this child been hospitalized since birth? ☐ Yes ☐ No

Age: _____ Date(s): _____
 Reason: _____
 Hospital: _____
 Full name of physician(s): _____

2. Have there been emergency room visits? ☐ Yes ☐ No

Age: _____ Date(s): _____
 Reason: _____
 Hospital: _____

3. Medication Please list all medications this child is currently taking:

Name	Dose	Date Began	Reason

Please provide full name of prescribing physician here: _____

4. General Health (Check or describe all that apply):

☐ Does this child have any health concerns, accidents, or injuries? _____

5. Allergies: Please list _____

6. Vision

Are there concerns about vision? ☐ Yes ☐ No If this child's vision has been checked,
 by whom? _____ Date _____

Vision check findings: _____

Does this child wear glasses/contact lenses? ☐ Yes ☐ No

7. Hearing

Are there concerns about hearing? ☐ Yes ☐ No

If 'Yes', check if applicable ☐ Child is deaf or hard of hearing ☐ Child wears hearing aids

If hearing has been tested, by whom? _____ Date _____

Result: _____

PART V - SPEECH AND LANGUAGE

What language(s) is/are spoken in the home? _____

Has this child ever had speech and language therapy? ☐ Yes ☐ No

Speech/Language Pathologist: _____

The following are areas of concern:

☐ following directions

☐ listening

☐ understanding language

☐ pronunciation

☐ drooling

Does this child (please give examples where necessary):

☐ respond to noises _____

☐ name people or things _____

☐ ask for help (e.g. "Open door") _____

☐ imitate others' speech _____

☐ greet _____

Is this child easily understood by family members? ☐ Yes ☐ No

Non-family members? ☐ Yes ☐ No

If there have been any recent changes (increase or decrease) in the way this child communicates, e.g. sounds, words, understanding, please describe: _____

PART VI - SENSORY-MOTOR

1. Which hand does this child prefer? ☐ right ☐ left ☐ no preference

2. Which of the following are concerns with this child.

0 = no problem

1=mild problem

2=severe problem

If you circle a 1 or 2, please comment next to the item.

0 1 2 dislike certain food textures

0 1 2 chew on non-food items (shirt, pencil, pen, rubber bands, etc.)

0 1 2 dislike touching certain textures (paste, clay, etc.)

0 1 2 dislike getting dirty

0 1 2 have difficulties with use of utensils

0 1 2 appear clumsy or off balance on the playground

0 1 2 overreact to loud noises

3. In what physical activities does he/she participate? _____

4. Describe any other concerns you have about the way this child moves. _____

5. Please list if this child uses special adaptive equipment, i.e. wheelchair, AFO's. _____

PART VII – ATTENTION SPAN AND ACTIVITY LEVEL

Please show which of the following are concerns with this child.

0 = no problem 1 = mild problem 2 = severe problem

- 0 1 2 short attention span
- 0 1 2 distractable
- 0 1 2 disinterest, boredom
- 0 1 2 daydreaming/tuning out
- 0 1 2 always on the go, overactive
- 0 1 2 acts before thinking, impulsive

PART VIII – LEARNING

Compared to other children his/her age, does this child seem to gain information and skills at a rate which is:

☐ Slower than average ☐ Average ☐ Faster than average

Does this child seem to retain information and skills learned? ☐ Yes ☐ No

Please indicate this child's day care/educational experience(s):

	Name of Agency	Age(s) attended
Day Care Center		
Play Group		
Nursery School		
Birth to Three		
Elementary School		

Dates of any educational testing at school? _____

School: _____ Town: _____

PART IX – BEHAVIOR / EMOTIONS

1. What are some of this child's strengths? _____
2. What do you like most about this child? _____
3. Under what circumstances does this child show undesirable behaviors? _____
4. Please describe any noticeable change in this child's personality/behavior within the last year?

5. What are this child's favorite play activities and interests?:

PART X – SOCIAL

1. Does this child play with children his/her own age? ☐ Yes ☐ No
2. Please comment on how this child relates to his/her friends and siblings:

3. Is this child's play on a parallel or an interactive level at this time? _____
4. Please show which of the following are concerns with this child.
0 = no problem 1 = mild problem 2 = severe problem

0 1 2 easily led by others
0 1 2 difficulty cooperating in a group
0 1 2 gets into fights
0 1 2 has no friends, can't get along with peers
0 1 2 limited peer/adult interaction
0 1 2 difficulty getting along with siblings

PART XI – PARENT/CHILD INTERACTION

(Please Circle your Answer)

	Mother		Father	
In general, do you agree with your spouse on how this child should be raised?	Yes	No	Yes	No
Do you enjoy taking care of this child?	Yes	No	Yes	No
Do you feel you are doing a good job raising this child?	Yes	No	Yes	No
Do you have bedtime rules?	Yes	No	Yes	No

In regard to the way you were raised, what, if anything, have you tried to change or avoid in raising this child?

PART XII – DISCIPLINE (Please Circle your Answer)

	Mother	Father
When this child needs discipline, do you:		
talk to him/her?	Yes No	Yes No
yell at him/her?	Yes No	Yes No
send him/her to his/her room or time out?	Yes No	Yes No
spank him/her?	Yes No	Yes No
Who usually disciplines this child? _____		
Is discipline effective?	Yes No	Yes No
Does this child need to be disciplined more than other children?	Yes No	Yes No

PART XIII – FAMILY CHANGES

If during the last year or two any of the following events occurred in your family, please specify:

births/deaths? _____

move? _____

job transfer? _____

separation/divorce? _____

accidents/serious illness? _____

Not including births, describe any new member added to your household?

Anyone who has left home? _____

Please provide family history and include child's parents, grandparents, siblings, aunts, uncles, cousins, etc. and please **note the relationship to child below:**