Alachua County Public Schools

Exceptional Student Education

Social/Developmental History

All information will remain confidential Date:_____

Family History

Child's Name:_____ Date of Birth:_____ Male ☐ Female ☐

Home Address:_____ Phone:_____

Phone:_____ Parent Work Phone:_____

School:_____ Grade:_____ Student #:_____

Person completing this form: Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐

Parent/Guardian #1:_____ Age:_____ Grade Completed:_____

Occupation:_____

Parent/Guardian #2:_____ Age:_____ Grade Completed:_____

Occupation:_____

Stepparent's Name:_____ Age:_____ Grade Completed:_____

Occupation:_____

Marital Status of Parents:_____ If divorced/separated, how old was child?_____

Were there any significant behavioral/emotional reactions by the child? Yes ☐ No ☐

If yes, please explain:_____

If both parents are not living in the home with the child, are there visitation arrangements? Yes ☐ No ☐

If yes, explain:_____

Siblings/Ages:_____

Other persons in the home (list name/relationship to child)_____

Primary language spoken at home:_____ Years lived in USA:_____

Other language(s) spoken at home:_____ Adopted Yes ☐ No ☐

Have any of the child's relatives had any of the following? (If so please, explain)

Speech/Language problems:_____

Academic difficulties:_____

Physical handicaps:_____

Mental Illness:_____

Health History

Please check all that currently apply

☐ Balance problems	☐ Emotional problems	☐ Memory difficulties	☐ Diabetes
☐ Nausea	☐ Head injuries	☐ High blood pressure	☐ Vision difficulties
☐ Convulsions	☐ Coordination Difficulties	☐ Loss of consciousness	☐ Tics
☐ Ear problems	☐ Seizures	☐ Glasses	☐ Asthma
☐ Frequent headaches	☐ Allergies	☐ Dizziness	☐ Stomach problems
☐ Tiredness or weakness	☐ Hearing aid	☐ High fevers	☐ Other:_____

Please explain any of the above:_____

Developmental/Medical History

Was the birth full term? ☐ Yes ☐ No Gestation Period:_____ weeks

Premature? ☐ Yes ☐ No Birth Weight:_____

Was mother under doctor's care? ☐ Yes ☐ No Prenatally substance exposed? ☐ Yes ☐ No

What was the health of mother before/during & after pregnancy?_____

Birth complications or birth defects? ☐ Yes ☐ No

If yes, please explain:_____

Any history of smoking, drinking or drugs of mother? ☐ Yes ☐ No

If yes, please explain:_____

Any feeding, sleeping or breathing problems? ☐ Yes ☐ No

If yes, please explain:_____

Developmental/Medical History

(continued)

Were there any special problems in growth and development during the first few years? ☐ Yes ☐ No

If yes, please explain:_____

Age when: Crawled:_____ Walked:_____ Toilet Trained:_____

Spoke First Word:_____ Spoke Short Sentence:_____

Has your child received any specialized medical evaluations? ☐ Yes ☐ No

If yes, please explain:_____

Does your child currently have any medical problems? ☐ Yes ☐ No

If yes, please explain:_____

Is your child currently taking medication(s)? ☐ Yes ☐ No

If yes, please *LIST*:_____

Any history of serious illnesses, accidents, operations, hospitalizations? ☐ Yes ☐ No

If yes, please explain:_____

Has your child received counseling/psychotherapy? ☐ Yes ☐ No

If yes, please explain:_____

Has your child been in foster care? ☐ Yes ☐ No

If yes, please explain:_____

Has there been any family involvement with Dept. of Children and Families? ☐ Yes ☐ No

If yes, please explain:_____

Is there a history of abuse of any form? ☐ Yes ☐ No

If yes, please explain:_____

Has your child ever been retained in school? ☐ Yes ☐ No

If yes, please explain:_____

Has your child ever had academic or behavior problems in school? ☐ Yes ☐ No

If yes, please explain:_____

Behavior History

Please check all that currently apply

- ☐ Temper tantrums
- ☐ Cries excessively
- ☐ Unusual fears
- ☐ Clumsy/falls often
- ☐ Bedwetting/soiling
- ☐ Frustrates easily
- ☐ Easily distractible
- ☐ Separation difficulties
- ☐ Can't sit still or fidgety
- ☐ Dislikes being touched/avoids physical contact
- ☐ Sleeps excessively
- ☐ Lacks self-confidence
- ☐ Runs or climbs on things excessively
- ☐ Seems unhappy
- ☐ Deliberately disobeys
- ☐ Short attention span
- ☐ Sleeping difficulties
- ☐ Runs from home
- ☐ Social loner
- ☐ Mood swings
- ☐ Overly sensitive to criticism
- ☐ Will not play with other children
- ☐ Ritualistic behaviors
- ☐ Has difficulty concentrating or paying attention
- ☐ Often acts without thinking
- ☐ Suicidal behavior/attempt
- ☐ Gives up easily
- ☐ Doesn't/can't follow directions
- ☐ Compulsiveness
- ☐ Eating difficulties
- ☐ Blames others for problems
- ☐ Doesn't seem to listen
- ☐ Needs a lot of supervision
- ☐ Aggressive/fights with other children
- ☐ Self injurious behavior
- ☐ Often fails to finish work
- ☐ Fire setting
- ☐ Lack of interest or pleasure
- ☐ Shifts excessively from one activity to another

How do you think your child feels about herself/himself?_____

Is your child overly sensitive to anything?_____

How would you describe your child's home behavior?_____

Docs your child display any unusual behavior?_____

How does your child interact with friends/siblings?_____

How would you describe your child's personality?_____

Is there anything else you would like to add about your child or family situation?_____

Interviewer Name:_____ Date:_____

Interviewer Position:_____