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 ☐
Mother's Name: ___________________ Age: ________ Grade Completed: ___________
Occupation: ___________________
Father's Name: ___________________ 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

"Yes" answers – please explain

What was the health of mother before, during and after pregnancy?

____

Birth complications or birth defects? ☐ Yes ☐ No
Explain: ___________________
Any history of smoking, drinking or drugs of mother? ☐ Yes ☐ No
Explain: ___________________
Any feeding, sleeping or breathing problems? ☐ Yes ☐ No
Explain: ___________________

continued on back

Developmental/Medical History
(continued)

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

Age when: Crawled ________ Walked: ________ Toilet Trained: ________
Spoke First Word: ________ Spoke Short Sentence: ________

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

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

Is your child currently taking medication(s)? ☐ Yes ☐ No
Explain: *(Please list)* ____________________

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

Has your child received counseling/psychotherapy? ☐ Yes ☐ No
Explain: ____________________

Has your child been in foster care? ☐ Yes ☐ No
Explain: ____________________

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

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

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

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