## HEALTH and SOCIAL HISTORY

Date: / /

Student's name: _____ Birth date: / / Phone: _____

School: _____ Grade: _____ Teacher: _____

Home address: _____ Primary language in home _____

Physical address: _____

Person(s) filling out form: Mother only_____ Father only_____ Both_____ Other_____

Father's Name: _____ Mother's Name: _____

Occupation: _____ Occupation: _____

Child's relationship to parents: Natural_____ Adopted_____ Stepchild_____ Other (Explain)_____

Child living with: Both parents_____ Father only_____ Mother only_____ Other (Explain)_____

Others living in home: _____

Family doctor: _____ Date of last physical exam / /

Previous schools attended (names and addresses): _____

_____

_____

Attendance problems? Yes____ No____ Explain _____

Has your child ever been retained? _____ If so, when? _____

Previous school services received (such as Special Education, Speech, Counseling, etc.) _____

_____

_____

Previous community services received (such as Social Services, Mental Health, etc.) _____

_____

_____

What are your expectations for your child at school in terms of performance and behaviors? _____

_____

What are your expectations for your child at home (chores, responsibilities, etc.)? _____

_____

Current concerns or problem areas you see with your child (academic, behaviors, speech, etc.): _____

_____

What, if anything, is happening in your family which might be contributing to your child's difficulties (recent move, chronic illness, divorce, unemployment,financial problems, etc.)? _____

_____

1. *Pregnancy and Birth*

A. PRENATAL

1. When this child was born, how old was the mother? _____ the father? _____
2. This child was born (1st, 2nd, 3rd, etc.) _____ of your children.
3. How long was this pregnancy? _____
4. What kind of problem(s), (bleeding, cramping, etc.), illnesses, or accidents, if any, happened during this pregnancy? _____
5. While pregnant, did you take any drugs other than vitamins or iron? _____
   If yes, what? _____
6. What kind of problems did you have with any other pregnancies? _____

B. PERINATAL

1. How long was labor?_____ Were there any difficulties during labor?_____
   If yes, what_____
2. Was the delivery regular vaginal?_____ forceps?_____ Caesarean?_____
3. What was the infant's birth weight?_____ birth length?_____
4. After the delivery, did the baby need oxygen?_____ If yes, how long?_____
5. Did the baby turn yellow enough to be treated?_____ If yes, what kind of treatment did the baby receive?_____
6. Did you take the baby home with you from the hospital? _____ If no, how long after and why?
   _____

## 2. *Developmental History*

A. DEVELOPMENTAL LANDMARKS

1. At what age did your child:
   Begin to crawl?_____ Begin to walk alone?_____
   Finish toilet training (bladder)?_____ (bowel)?_____
   Begin saying words (not "mama" or "dada")?_____
2. Did you or anyone else have any serious concerns that your child was not growing well?_____
   If yes, explain_____

B. TEMPERAMENT at ages 2 to 5 years

1. Did your child show the following:
   Short interest or attention span?_____ Restlessness?_____
   Frequent temper tantrums?_____ Destructiveness with toys?_____
   If yes to any of the above, please explain:_____
   _____

C. LEARNING SKILLS

1. How old was your child when: She/he knew her/his colors?_____
   Everyone could understand her/his speech?_____ She/he stopped reversals (d/b) in writing?_____She/he would sit through a full 1/2 hour of TV cartoons?_____
   She/he could listen to a story for more than 10 minutes?_____

## 3. *Current Health Habits and Other Behavior*

A. Does your child:
   Feed her/himself well?_____ Have any problems eating certain foods?_____
   Have a good appetite?_____ a poor appetite?_____ Get enough to eat?_____

B. How much sleep does she/he get at night?_____ naps?_____

C. Does your child: Dress her/himself well?_____ Pick out her/his own clothes?_____
   Ever need help dressing?_____ With what?_____

D. Does she/he ever wet the bed?_____ If yes, how often?_____
   When did she/he last wet the bed?_____

E. Does she/he have soiling problems?_____ If yes, how often?_____
   Night time or day time?_____When did she/he last have a problem?_____

F. Does she/he have any habits such as thumbsucking or nail biting?_____

G. How much exercise does your child get?_____

H. Is there anything she/he is particularly afraid of?_____ Explain:_____
   _____

I. How much time do you think your child spends daydreaming?_____

J. To your knowledge, what kinds of experience has your child had with:
drugs?_____ alcohol?_____

4. ***Personality traits***

A. Describe your child in terms of strengths and weaknesses
Strengths_____

_____

Weaknesses_____

_____

C. Does your child cry easily?_____ What makes her/him cry?_____

_____

D. What kind of temper does your child have?_____
What makes her/him lose his temper?_____
What does she/he do when angry?_____

E. What form of discipline do you use?_____ Is it effective?_____
Any serious marital disagreement when disciplining your children?_____

F. Does your child make friends easily?_____ Are her/his friends mostly her/his age?_____
younger?_____ older?_____

G. What does your child like to do for fun?_____
Does she/he prefer to play indoors?_____ outdoors?_____

H. Describe your child in terms of getting along with other family members:_____

_____

I. Describe your child's feelings about her/himself:_____

_____

J. Describe your child's motivation to achieve:_____

_____

K. Describe your child's attitude about school:_____

_____

5. ***Significant Health Problems, Illnesses, and Complaints***

A. PAST PROBLEMS

1. What operations (surgery) has your child had and when?_____

_____

_____

2. What injuries has she/he had serious enough for a doctor's care (stitches, casts, etc.) and when?

_____

_____

3. Has your child ever received a serious blow to the head?_____ Had a skull fracture?_____
If yes, explain:_____

4. Has your child ever lost consciousness (been knocked out), either from an injury or fainting?_____
If yes, explain:_____

5. Has your child ever been exposed to unusual amounts of lead? _____ If yes, explain:_____

_____

B. CURRENT PROBLEMS

1. Is your child now under regular medical care for any condition?_____ If yes, what?_____

_____

2. Is she/he currently taking any medications?_____ If yes, what?_____

3. Does your child have any chronic problems such as:

asthma_____ allergies_____ seizures_____ diabetes_____ other_____

Describe:_____

4. Is your child frequently ill with such things as:

colds_____ how often?_____

ear infections_____ how often?_____

other_____ how often?_____

5. Does your child have any vision or hearing problems? _____ If yes, explain:_____

_____

6. What physical or mental handicaps does your child have?_____

_____

C. CURRENT HEALTH CHECKLIST

Please circle any of the following items that apply NOW to your child's health. (Explain below)

1. EENT (Eye, Ear, Nose Throat): double vision, tearing, blurring, eye discharge, crossed eyes, glasses to correct a vision problem, colds, sore throats, earaches, stuffy nose, hearing, smelling, taste, mouth breathing, snoring, sneezing, nosebleeds, dental problems.
2. CARDIO-RESPIRATORY: shortness of breath, wheezing, coughing, chest pain, swelling, turning blue with exercise, cold hands or feet.
3. GASTRO-INTESTINAL: vomiting, diarrhea, constipation, abdominal pain, jaundice(yellow skin or eyes), bowel control, rectal bleeding, nausea, pinworm symptoms (itchy rectum).
4. GENITO-URINAL: urinates too frequently, pain, blood in urine, vaginal discharge, abnormal menstrual history, abnormalities of penis and testes, bladder control.
5. NEURO-MUSCULAR: tingling, numbness, headaches, dizziness, seizures (fits), shaking, twitching, blackouts, problems with posture, deformities, gait, personality changes, unconsciousness, general speech.
6. SKIN: itching, irritation, perspiration, growths, rash, excessive dryness, unusual skin color, nail or hair problems.

Explanation:_____

_____

_____

D. FAMILY HEALTH HISTORY

1. Please list the name and ages of blood relatives (immediate family) and health problems (diabetes, epilepsy, mental retardation, physical deformity, alcoholism, growth problems, etc.) they may have (had):

| NAME | AGE | Relationship | Health Problems |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Has anyone in the family (including parents) had any learning or other school problems?_____

If yes, explain:_____

SIGNATURE OF PARENT (S), GUARDIAN, ETC._____