EVSC
Evansville Vanderburgh School Corporation

Social Developmental History
(Parent Information Form)

Instructions: Please complete this form to the best of your knowledge. The information you provide will assist the Educational Intervention Team in planning and developing appropriate strategies. This form is also used by the school psychologist and other school personnel should a psycho-educational evaluation be recommended.

Student Identifying Information		
Student's Name:		
Date of Birth & Current Age	/ / Age:	Today's Date: / /
Person Completing Form	Your Name:_____ Do you have legal custody? Yes or No Relationship to Child: _____ (circle one)	
Schools child has attended and length of attendance: (Include Preschools)	Name of School	Year

Family Information	
Home Address:	Parent(s)/Guardian(s): _____ Street Address: _____ City: _____ State: _____ ZIP Code: _____ County: _____ Email Address:_____ Best Phone Number to Reach Parent(s): _____
Parent/Guardian Information: Name:_____ ☐ Biological parent ☐ Other Relative_____ ☐ Step-parent ☐ Unrelated ☐ Adoptive parent ☐ Foster parent ☐ Grandparent	☐ Male ☐ Female Age: _____ Education: _____ Work Title:_____ Employer: _____
Parent/Guardian Information: Name:_____ ☐ Biological parent ☐ Other Relative_____ ☐ Step-parent ☐ Unrelated ☐ Adoptive parent ☐ Foster parent ☐ Grandparent	☐ Male ☐ Female Age: _____ Education: _____ Work Title:_____ Employer: _____
The Child's Parents Are:	☐ Married ☐ Divorced (date: _____) ☐Separated ☐Never Married/No Longer Together ☐ In a Committed Relationship
Please list all brothers and sisters; including full, half and step-siblings.	Living with the child? Name: _____ Age: _____ ☐ yes ☐ no Name: _____ Age: _____ ☐ yes ☐ no Name: _____ Age: _____ ☐ yes ☐ no Name: _____ Age: _____ ☐ yes ☐ no Name: _____ Age: _____ ☐ yes ☐ no
Please list anyone else living in the child's home, and indicate their relationship to the child.	
Please describe your specific concerns about your child's educational needs.	

Pregnancy and Birth History	
Mother's age for this pregnancy and number of this pregnancy:	Age:_____ This pregnancy was : ☐ 1st ☐ 2nd ☐ 3rd ☐ ____th
Did the birth mother have any health problems or take any medications during pregnancy?	☐ No ☐ Yes: (please describe) _____
Did the birth mother smoke during pregnancy?	☐ No ☐ Yes If "Yes," how much? _____ and how often? _____

Did the birth mother consume alcohol or drugs during pregnancy?	☐ No ☐ Yes If "Yes," how much? _____ and how often? _____
Delivery Type:	☐ Vaginal ☐ Emergency Cesarean Section ☐ Scheduled Cesarean Section
Complications during delivery: (forceps used, breech position, etc.)	☐ No ☐ Yes (please describe) _____
The baby was born:	☐ Full Term ☐ Premature (_____weeks early) ☐ Late Birth Weight: _____lb. _____oz.
Did the baby breathe on his/her own right away?	☐ No ☐ Yes Apgar Scores (If known): One Minute _____ Five Minutes _____
How soon after birth was the baby allowed to go home with you?	
Any problems during the first year of life (hospitalizations, surgeries, medical problems etc.)? If yes, please describe.	☐ No ☐ Yes _____
Developmental History	
Motor	
At what age did the child:	Sit up: _____ Crawl: _____ Walk: _____
Handedness:	☐ Right ☐ Left ☐ Both
Has the child ever received Occupational Therapy (OT) or Physical Therapy (PT)?	☐ No ☐ Yes (please explain) _____
Language	
At what age did the child:	Speak first word: _____ Put 2-3 words together: _____
Any history of poor sucking, problems chewing, or late drooling?	☐ No ☐ Yes (please explain) _____
Any history of speech delays or problems (e.g. difficult to understand, stuttering)?	☐ No ☐ Yes (please explain) _____
Has the child participated in Speech/Language therapy?	☐ No ☐ Yes (please explain) _____
Language(s), other than English, spoken in the home?	
If more than one language is spoken in the home:	Date when child was first exposed to English in conversation: _____ Date when child was first exposed to English in print form: _____
Toileting	
Any problems with bed wetting or daytime toileting accidents?	☐ No ☐ Yes (please explain) _____
Temperament & Social Development	
As a baby was your child easy to comfort or soothe?	☐ Yes ☐ No (please explain) _____
Any trouble getting along with other children his/her age?	☐ No ☐ Yes (please explain) _____
Does your child have difficulty making or keeping friends?	☐ No ☐ Yes (please explain) _____
The child gets along with:	(Check all that apply) Children: ☐ Same age ☐ Younger ☐ Older ☐ Adults
Does your child have difficulty sitting still?	☐ No ☐ Yes If yes, please indicate the approximate age of the child when you first noticed this behavior. _____
Does your child have difficulty paying attention?	☐ No ☐ Yes If yes, please indicate the approximate age of the child when you first noticed this behavior. _____
Which of the following best describes your child in social interactions?	☐ Joins in freely with a group of children. ☐ Is sometimes uneasy to join other children, but does so when encouraged. ☐ Hardly ever plays with other children, but instead prefers to play by him/herself. ☐ Only interacts with family members. ☐ Does not typically interact or seek out social exchanges.

Check the following behaviors/characteristics that typically describe your child: (check one for each number)	1) ☐ Positive self-concept ..... Low self-esteem ☐ 2) ☐ Nondisruptive ..... Disruptive ☐ 3) ☐ Outgoing ..... Withdrawn ☐ 4) ☐ Observes rules ..... In trouble in school ☐ 5) ☐ Leader ..... Follower ☐ 6) ☐ Responsible ..... Irresponsible ☐ 7) ☐ Enjoys school ..... Dislikes school ☐ 8) ☐ Shows initiative ..... Passive ☐ 9) ☐ Gets along with others ..... Fights ☐ 10) ☐ Respects authority figures ..... Defies authority figures ☐ 11) ☐ Follows directions ..... Does not follow directions ☐ 12) ☐ Works independently ..... Often requires help ☐ 13) ☐ Motivated ..... Poorly motivated ☐ 14) ☐ Tolerates frustration ..... Easily frustrated ☐ 15) ☐ Trusts others ..... Distrusts ☐ 16) ☐ Respects property ..... Destructive ☐ 17) ☐ Prepared for class ..... Not prepared for class ☐ 18) ☐ Compliant ..... Manipulative ☐ 19) ☐ Good memory ..... Forgetful ☐ 20) ☐ Stays on task ..... Distractible ☐ 21) ☐ Organized ..... Poorly organized ☐ 22) ☐ Appropriate activity level ..... Overactive ☐ 23) ☐ Thinks things through ..... Impulsive ☐ 24) ☐ Self-confident ..... Anxious ☐ 25) ☐ Keeps friends ..... Poor social relationships ☐ 26) ☐ Learns easily ..... Learning difficulties ☐ 27) ☐ Understands feelings of others ..... Aggressive ☐ 28) ☐ Rarely complains ..... Complains often ☐ 29) ☐ Controls temper ..... Angry ☐ 30) ☐ Seems happy ..... Sad ☐
Check factors affecting the family: (check all that apply and please explain)	☐ Blended family problems ☐ Parent-child conflict ☐ Unemployed ☐ Divorce/separation ☐ Sibling conflict ☐ Custody problems ☐ Frequent moves ☐ Incarcerations ☐ Parent conflict ☐ Substance Abuse ☐ Death of family member ☐ Recent move ☐ Serious illness ☐ Other Please explain: _____
Has your child/family had contact with a social agency, psychiatrist, psychologist, clinic, or private agency?	☐ No ☐ Yes (please explain) _____ Previous Psychological Evaluations? _____ When: _____ Where (EVSC, other school corporations, The Rehabilitation Center, Deaconess Cross Pointe, etc.): _____
Has the child ever participated in counseling?	☐ No ☐ Yes When: _____ Where: _____ Reason for counseling: _____
Child/Family Medical History	
Date of child's last doctor's visit?	☐ Less than 6 months ago ☐ 6 – 12 months ago ☐ 1 to 2 years ago ☐ More than 2 years ago
Any problems with vision or hearing?	☐ No ☐ Yes (please describe) _____
Child has had recurrent ear infections/tubes placed in ears:	☐ No ☐ Yes (please describe, include dates of surgery) _____
List any serious illnesses or injuries, hospitalizations or surgeries.	☐ None List incidents and hospitalizations with dates: _____
Describe any head injuries (date, what happened, changes in behavior after the injury)	
Has the child been exposed to environmental toxins (e.g. lead, dioxin, etc.)	☐ No ☐ Yes (please describe dates and amount of exposure) _____
Has the child had: (check all that apply). Please list dates	☐ Allergies _____ ☐ Arthritis _____ ☐ Asthma _____ ☐ Diabetes _____

and treatments.	☐ Fever-related or other Seizures_____ ☐ Bleeding disorders_____ ☐ Exposure to radiation_____ ☐ Urinary problems _____ ☐ Chicken pox _____ ☐ Febrile Seizures _____ ☐ Frequent colds or sore throat_____ ☐ Nose bleeds_____ ☐ Frequent stomach aches_____ ☐ Worries a lot _____ ☐ Frequent use of toilet_____ ☐ Hepatitis_____ ☐ Substance abuse _____	☐ Epilepsy_____ ☐ Exposure to chemotherapy_____ ☐ Heart condition _____ ☐ Orthopedic problems _____ ☐ Measles/Rubella _____ ☐ High fevers _____ ☐ Frequent coughs_____ ☐ Frequent headaches_____ ☐ Frequent toothaches _____ ☐ Frequent nightmares _____ ☐ Frequent constipation _____ ☐ Broken bones _____ ☐ Other _____
Are any of these true for your child: (check all that apply)	☐ Temper tantrums ☐ Clumsiness ☐ Sleep difficulties/tires easily ☐ Eating difficulties ☐ Self-injurious behavior ☐ Suicidal feelings or actions ☐ Depressed or sullen mood	
Current medications, dosage, reason for taking medication, and prescribing physician (include over-the-counter medications):	Current medication(s):_____ _____ Reason:_____ Prescribing Physician:_____	
Do any family members have a history of learning problems?	☐ No ☐ Yes (please explain) _____ _____	
Is there family history of mental health problems?	☐ No ☐ Yes (please describe) _____ _____	
Relevant family medical history: (please indicate person's relationship to student)	☐ Asthma _____ ☐ Anemia _____ ☐ Diabetes _____ ☐ Heart Disease _____ ☐ Cancer _____ ☐ High blood pressure____ ☐ Mental Retardation _____ ☐ Epilepsy _____ ☐ Kidney Problems _____ ☐ Substance abuse _____ ☐ Other serious illness_____	

Consulting Professionals & Other Professionals

Please list all others involved in your child's care including: physicians, psychologists, social workers, therapists, case workers, or probation officers.

Name/Profession	Nature of their involvement
Name/Profession	Nature of their involvement
Name/Profession	Nature of their involvement

Child's Strengths/Additional Comments

Please use the space below to describe your child's strengths and provide any additional comments.

SIGNATURE OF PERSON COMPLETING FORM _____ DATE_____
(YOUR SIGNATURE ON THIS FORM DOES NOT IMPLY CONSENT FOR EVALUATION.)

SIGNATURE OF PRINCIPAL_____**DATE RECEIVED BY PRINCIPAL**_____