BOONE-CLINTON-NORTH WEST HENDRICKS JOINT SERVICES
1122 N. Lebanon St., Lebanon, Indiana 46052
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SOCIAL AND DEVELOPMENTAL HISTORY FORM

Student Name: _____ □ Male □ Female
First Middle Last
School Attending: _____ Grade _____ Date of Birth_____

Guardians' Names: _____

Current Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Guardian's Email: _____

FAMILY HISTORY

Legal Guardianship:

□ Biological Mother
□ Biological Father
□ Step-father
□ Step-mother
□ Adoptive Mother
□ Adoptive Father
□ Foster Family
□ Guardian (specify): _____

Marital Status of Parents

□ Married
□ Single
□ Married but living apart
□ Other _____
□ Divorced (Check custodial status)
□ Joint Custody
□ Sole Custody (Which parent?) _____
□ Yes □ No Does the child have visitation with non-custodial parent?

Please list the names and ages of all people currently living at your child's residence:

Name	Relationship to Child	Age	Highest Grade Achieved

MEDICAL HISTORY

Describe any complications, medications, or other concerns experienced during the pregnancy (e.g., gestational diabetes, high blood pressure, preecplampsia, toxemia, etc) _____
At the time of birth/delivery:
Was the child full term? □ Yes □ No Duration of Pregnancy: _____
Cesarean section? □ Yes □ No Birth Weight: _____
Please describe any birth or delivery complications: _____

List any serious illnesses, injuries, hospitalizations, surgeries, or traumatic events (e.g., diabetes, seizures, convulsions, concussions, asthma, allergies, etc.) Child's Age at the Time

Current Medical Diagnosis	Medical Provider's Name	Date of Diagnosis	Prescribed Medication

Please attach any pertinent physician reports or diagnostic statements

Does the child have a family history (biological parents, siblings, grandparents, aunts, uncles, cousins) of any of the following?

□ Learning difficulties (reading, spelling, writing, math, organization)
□ Speech or language difficulties (articulation, stuttering, organizing/recalling words, etc.)
□ Emotional difficulties (depression, anxiety, mood disorder, psychosis, etc.)
□ Cognitive difficulties (may have been called mental retardation or mental handicap)
□ Genetic medical conditions impacting developmental, learning, and emotional health
□ Abuses or domestic violence
□ Substance abuse (drugs or alcohol)
□ Other: _____

Does your child experience any of the following:

Vision problems? □ Yes □ No Glasses? □ Yes □ No Contacts? □ Yes □ No
Date of recent vision exam _____ Results _____
Describe any vision sensitivity: _____

Hearing problems? □ Yes □ No Age detected: _____ Tubes in ears? □ Yes □ No Date: _____
Hearing aids? □ Yes □ No Cochlear implant? □ Yes □ No
Date of recent hearing exam _____ Results _____
Describe any hearing sensitivity: _____

Sleep problems? □ Yes □ No Describe: _____

Taste problems? □ Yes □ No Describe: _____

Touch problems? □ Yes □ No Describe: _____

Other: _____

What is your child's primary language? _____What other languages are spoken at home? _____

Did the child demonstrate the following behaviors within an age-appropriate time line?

Behavior	Normal Age Range	
Rolled over	4-6 months	□ Yes □ No □ Don't know/Not yet shown
Sat alone	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Crawled	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Stood alone	12-15 months	□ Yes □ No □ Don't know/Not yet shown
Walked alone	12-15 months	□ Yes □ No □ Don't know/Not yet shown
Babbled	6-9 months	□ Yes □ No □ Don't know/Not yet shown
Spoke first word	9-12 months	□ Yes □ No □ Don't know/Not yet shown
Combined words together	18-24 months	□ Yes □ No □ Don't know/Not yet shown
Toilet trained during the day	22-24 months	□ Yes □ No □ Don't know/Not yet shown

Please check early intervention services received when your child was a toddler: □ Speech and Language □ Developmental Therapy □ Physical Therapy □ Occupational Therapy □ Behavioral Therapy
□ Other: _____

SCHOOL HISTORY

Daycare/Preschool/School Attended	Date of Attendance

If your child repeated a grade, what grade was repeated? _____ School: _____
Reason for retention? _____

Has your child received private interventions or evaluations to assist with school progress?
□ Educational services from private entity (e.g., private tutor, Sylvan, Learning Rx, Lindamood Bell, etc.)
□ Therapy services from private entity (e.g., speech, occupational therapy, physical therapy, vision therapy, behavioral therapy, etc.)
□ Private evaluations/previous school evaluations (***please attach previous educational reports***)

Please describe the following:
Your child's school strengths: _____
Your child's school weaknesses: _____
Your child's study habits at home: _____
Your child's attitude toward school: _____

BEHAVIORAL HISTORY

Please check behaviors deemed to be a **significant** concern at this time:

□ Fidgets, is easily distracted,
□ Has a hard time staying seated
□ Shifts quickly from one activity to another
□ Poor concentration
□ Difficulty following instructions
□ Difficulty playing quietly
□ Engages in impulsive behavior
□ Immature compared to peers
□ Depressed/sad mood
□ Sleeping too little
□ Low energy/fatigue
□ Excessive separation difficulties
□ Overly anxious or fearful
□ Temper tantrums
□ Rapid mood changes/mood swings
□ Defies adult requests and rules
□ Deliberately annoys others
□ Angry/resentful
□ Poor appetite
□ Often complains about bodily aches
□ Often is truant or late
□ Lies
□ Substance abuse: □ drugs □ alcohol
□ Stereotyped mannerisms
□ Atypical/unusual fascinations or thoughts
□ Fire setting
□ Destroys others' property
□ Talks excessively, interrupts often, doesn't listen
□ Often loses things, very disorganized
□ Has difficulty waiting his/her turn or in line
□ Difficulty initiating tasks
□ Difficulty completing tasks
□ Often is loud
□ Engages in physically dangerous activities
□ Difficulty making decisions
□ Feelings of worthlessness or low self-esteem
□ Sleeping too much
□ Repeatedly has nightmare/night terrors
□ Shy/withdrawn
□ Cries easily
□ Argumentative with: □ adults □ peers
□ Suicidal thoughts/acts
□ Blames others for mistakes
□ Physically aggressive towards: □ peers □ adults
□ Easily frustrated
□ Overeats
□ Excessive worry about: □ events □ others
□ Excessive need for reassurance
□ Steals
□ Often swears or uses obscene language
□ Compulsive rituals
□ Hallucinations: □ Visual □ Auditory
□ Self-mutilation/self-injury
□ Harms animals

Does your child display any of the following atypical behavioral patterns?

- □ Preoccupation with specific topics or objects
- □ Not understand or aware of others' views
- □ Desires things to be in a specific way and routine
- □ Trouble understanding jokes and humor
- □ Difficulty adjusting to changes in plans/routines
- □ Eccentric forms of behavior
- □ Atypical facial or emotion responses to situations
- □ Unusual mannerisms and ways to move body
- □ Difficulty adjusting to new surroundings
- □ Other: _____

Please indicate and specify reasons your child received the following:

- □ Counseling _____
- □ Department of Children's Services _____
- □ Juvenile court or probation _____
- □ Mental health hospitalization _____
- □ Psychological evaluation _____

**** Please attach relevant reports.***

SOCIAL HISTORY

How does your child get along with adults at home?

How does your child get along with siblings in the home?

How does your child get along with peers?

How many friends does your child have? _____ What activities does your child do with his/her friends?

What are your child's favorite activities?

What are your child's behavioral and social strengths?

What are your child's behavioral and social weaknesses?

Other information you believe may be relevant to in the evaluation of your child: