**SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE**

## I. GENERAL INFORMATION

Child's full name_____ DOB_____ Age_____ Grade_____

Person(s) providing information: _____Date:_____

Relationship to child_____

**Reason for Referral**

Primary Concerns: What questions are you hoping to answer with this evaluation:

What do you feel are your child's:

Strengths:

Challenges:

## II. Educational History

### A. Current School

School Name_____Grade_____

Classroom teachers_____

Academic strengths:

Academic challenges:

To the best of your knowledge, at what grade level is your child functioning?

_____ Reading _____ Spelling _____ Math

Has your child ever had to repeat a grade? _____ If so, when? _____

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? ☐ Yes ☐ No

If yes, what services, when did they begin?_____

Describe Services: _____

Has your child ever participated in Child Find/Infants and Toddlers? ☐Yes ☐ No

If so, when:

How does your child feel about school?

_____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? ☐ Not a struggle ☐ Sometimes a struggle ☐ Often struggles

Describe_____

_____

_____

What have you tried to improve homework:

_____

_____

**B. Previous School History**

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool:

Strengths _____

Challenges: _____

Pre-kindergarten:

Strengths _____

Challenges: _____

Elementary School

Strengths _____

Challenges: _____

**III. Family History**

**A. Family information**

Who does child live with: ☐ both parents ☐ mother ☐ father ☐ other (specify)? _____

Caregiver 1: _____ Highest degree earned: _____

Occupation_____

Caregiver 2: _____ Highest degree earned: _____

Occupation_____

Please list all people living in the house and the relationship to the student.

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list all other *non-family* members who live in household: _____

_____

Please list any pets living in the home:_____

Language(s) spoken at home _____ Primary Language at home _____

Are biological parents of child currently: ☐ married ☐ separated ☐divorced ☐ never married

- If separated or divorced, who has *legal* custody? ☐ mother ☐ father ☐ other (specify): _____

_____

- If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

_____

Are there other adults who have a **significant part** in raising your child? ☐Yes ☐No

- If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.) _____

_____

How many hours per day is this child in a child-care setting? _____

Before school care? ____Yes _____No After School care? ____Yes _____No

Family Stressors: Have there been any significant changes or stressors in the home over the *last few years*? (Such as new marriages, deaths, births, family separations/divorce, parent dating, parent job change, financial problems, etc.) _____

_____

_____

_____

_____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace _____ Moved at age _____ grade _____
2. _____ Moved at age _____ grade _____
3. _____ Moved at age _____ grade _____

## B. Family History

| Is there a **family history** for the following problems? | *Biological* family member with the history ((parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc). Pleas specific the nature of the difficulties. |
|---|---|
| ☐ Learning Difficulties (reading, math, writing, spelling) Specify | |
| ☐ Speech or Language problem (articulation, stuttering, etc.) Specify | |
| ☐ Developmental Disorder (such as Autism, Asperger's disorder, intellectual disability, etc.) Specify | |
| ☐ Attention, Hyperactivity, or Impulsivity problems. | |

| | |
|---|---|
| ☐ Anxiety (e.g., fear of social situations, phobias, excessive worry, trauma) | |
| ☐ Mood difficulties (depression, mood swings, etc.). Specify | |
| ☐ School Problems (held back, failing grades, dropout, etc) | |
| ☐ Drug or Alcohol Addiction | |

## IV. HEALTH AND DEVELOPMENT

### A. Pregnancy and Birth

Is your child: ☐ biological child ☐ adopted child ☐ foster child ☐ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? ☐Yes ☐ No Please specify any medications used during pregnancy and the reason used: _____

_____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds _____ounces Did child go home from the hospital at the same time as the mother? ☐Yes ☐ No

If No, explain why: _____

**Please check the conditions below that describe the health of the child and mother during…**

| Pregnancy | Child's Delivery | Child's Condition at Birth |
|---|---|---|
| ☐ No complications | ☐ Normal | ☐ Normal |
| ☐ Blackouts | ☐ Induced labor | ☐ Lack of oxygen |
| ☐ Falls | ☐ C-section | ☐ Breathing problem |
| ☐ Physical injury | ☐ Breech birth | ☐ Birth injury/defect |
| ☐ Excessive bleeding | ☐ Unusually long labor (>12 hours) | ☐ Jaundice |
| ☐ Hypertension | ☐ Premature # of weeks | ☐ Newborn ICU # of days |
| ☐ Diabetes | ☐ Overdue # of weeks | ☐ Other problem (specify) |
| ☐ Emotional stress | ☐ Other problem (specify) | |
| ☐ Toxemia | | |
| ☐ Alcohol and/or drug use | | |
| ☐ Use of tobacco | | |

### B. Development

Please indicate the age or range when your child performed the following milestones

| Milestone | specify age |
|---|---|
| First steps independently | |
| Spoke first words | |
| Spoke 2-3 word phrases | |

| | |
|---|---|
| Fully bladder trained | |
| Fully bowel trained | |
| Stayed dry all night | |

During your child's first ***few years of life***, were any of the following present to *significant* degree?

- ☐ Did not enjoy cuddling
- ☐ Not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything

* Comments

**C. Health**

Describe the state of your child's **current** health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of Most Recent Physical_____ Concerns?_____

Is your child currently taking any medication? ☐Yes ☐ No

If yes, please list medications and uses: _____

_____

| Has your child had any of the following? Please check all that apply. | Please describe and give details, dates, and/or age of onset |
|---|---|
| ☐ Serious Illnesses | |
| ☐ Head Injuries | |
| ☐ Seizures or convulsions | |
| ☐ Surgery/Hospitalization | |
| ☐ History of Ear Infections | |
| ☐ Allergies and/or Asthma | |
| ☐ Vision Problems | |
| ☐ Hearing Problems | |
| ☐ Frequent Nightmares and/or Bedwetting | |

| | |
|---|---|
| ☐ Other health problem | |

## V. Treatment History

**A. Evaluation History**: Has your child ever been identified as having a disability? ☐Yes ☐ No

If so, by whom, what age, & what disability? _____

_____

Has your child ever received a psychological evaluation (e.g., intellectual, diagnostic, neuropsychological, academic)? ☐Yes ☐ No When? _____

Summary of Results/Diagnoses: _____

_____

**B. Therapy History**

Has your child ever received **psychological counseling** speech, occupational, physical, vision therapy etc? If so, complete below. (use back of page, if needed):

| Professional/Agency | Services (e.g., social skills, CBT, Medication) | Child age | Problems Addressed | Outcome | Satisfied Y/N Why? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## VI. BEHAVIOR

**A. Child's Temperament: (*current*):**

☐ Activity Level – How active has your child been from an early age? _____

_____

☐ Distractibility – How well is your child able to maintain focus or concentration, or pay attention to tasks? _____

_____

☐ Adaptability - How well is your child able to deal with transition, change, or when denied his/her own way? _____

_____

- Mood – What was your child's basic mood? Does he/she exhibit frequent or rapid changes in mood or temperament? _____

_____

- Regularity – How predictable is your child's patterns of activity level, sleep, appetite, etc.? _____

_____

Prior to age six, did your child have more difficulty than other children his/her age…

| | | | |
|---|---|---|---|
| ☐ | Sitting still at mealtime | ☐ | Staying focused on TV, movies, or video games |
| ☐ | Paying attention when read to | ☐ | Waiting for a turn to play |
| ☐ | Throwing a ball | ☐ | Knowing left and right |
| ☐ | Catching a ball | ☐ | Acting without thinking |
| ☐ | Buttoning and zipping | ☐ | Dressing self |
| ☐ | Holding a crayon or pencil | ☐ | Tying shoe laces |
| ☐ | Accidentally dropping things | ☐ | Accidentally knocking things over |

Comments: _____

_____

**B. Home Behavior:**

How often is each of the following settings a *problem for* your child?

| | | | |
|---|---|---|---|
| While getting ready for school | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When eating at the dinner table | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When playing by him/herself | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When playing with siblings/other children | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When with a babysitter or daycare | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| In public places (church, store) | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When in the car | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When told to do something he/she doesn't want to do | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| During sit-down homework time | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| When watching TV or playing video games | ☐ Rarely | ☐ Sometimes | ☐ Frequently |

How does your child get along with brothers/sisters? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

List any responsibilities your child has at home: _____

Does your child do these responsibilities regularly? ☐ Yes ☐ No

Does your child need frequent reminders? ☐ Yes ☐ No

Bed time? ____:____PM Wake time? ____:____ AM  Does child sleep well? ☐ Yes ☐

No Explain:

**C. Social Behavior:**

How many friends does your child have? _____

Does your child have a best friend? ☐ Yes ☐ No If yes, how long have they been friends? _____

Is your child shy, outgoing, a leader, or a follower? Circle one

Does child associate w/ scholars or troublemakers? Circle one

Does your child struggle to initiate interactions with other children? ☐ Yes ☐ No

Does your child struggle picking up on and/or interpreting social cues? ☐ Yes ☐ No

Does your child struggle to solve problems with peers? ☐ Yes ☐ No

How does your child interact with children in the neighborhood? At _____

_____

What are your concerns about your child's peer relationships and choice of friends? _____

_____