

**Davis School District Special Education  
Child Health and Developmental History Form**

*The information obtained on this form is confidential and will be used for educational purposes only.*

Current Date:

<b>General Information</b>					
Student ID :		Student Name (Last, First):			
Date of Birth:			Grade:		
Street Address:			City:		
State:		Zip Code:		Phone:	
Student lives with (guardian/parent names):			Relationships:		
How many brothers and sisters does this student have?		Full:	Half:	Step:	
Ages of brothers and sisters living at home:		Brothers' Ages:		Sisters' Ages:	
Student's First Language Spoken:			Student's place of birth:		
Guardians'/Parents' Native Language:			Student's previous places of residence:		
<b>Family Medical and Educational History</b>					
Are there any diseases that run in the family?		<input type="checkbox"/> Alcoholism		<input type="checkbox"/> Depression	
<input type="checkbox"/> Cancer: (type)		<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Other: (describe)					
Are there any family members that had difficulty in school? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, please describe:					
<b>Student's Birth History</b>					
Age of mother at time of student's birth:			Age of father at time of student's birth:		
How many pregnancies for the mother?			Which pregnancy was this student?		
Pregnancy Details:	<input type="checkbox"/> Full Term	<input type="checkbox"/> Premature (How early_____?)		<input type="checkbox"/> Bleeding	<input type="checkbox"/> Excessive Vomiting
<input type="checkbox"/> Illness of mother (please describe):					
<input type="checkbox"/> Other than vitamins, medications taken by the mother during pregnancy (please list):					
<b>Delivery</b>	Hours of labor:		<input type="checkbox"/> Cesarean	<input type="checkbox"/> Forceps	<input type="checkbox"/> Breech
	Medications given during labor:				
<b>Condition at Birth</b>	Weight:	Length:	Apgar scores if known:		
	<input type="checkbox"/> Incubator		<input type="checkbox"/> Trouble Breathing		<input type="checkbox"/> Needed Oxygen
	Length of stay in the hospital:				
	Other information about condition at birth:				
<b>Developmental History</b>					
Please indicate at what age your student did the following:					
Sitting up:		Crawling:		Walking:	
Talking (more than 2 words):		Slept through the night:		Bladder Control:	
Bowel Control:		Independent toileting:		Dry at night:	

<b>Habits</b>	<input type="checkbox"/> Thumb sucker, until what age?		
	<input type="checkbox"/> Favorite blanket/stuffed animal, until what age?		
	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Aggressive toward siblings/other children	<input type="checkbox"/> Passive (hard to motivate)
	<input type="checkbox"/> Picky eater	<input type="checkbox"/> Eats well	<input type="checkbox"/> Head banging
	<input type="checkbox"/> Overactive		
<b>Current Sleep Habits</b>	Other:		<input type="checkbox"/> Nail Biting
	Average hours per night:		<input type="checkbox"/> Light sleeper
	<input type="checkbox"/> Sound sleeper	<input type="checkbox"/> Restless	<input type="checkbox"/> Nightmares
	<input type="checkbox"/> Walks in his/her sleep	<input type="checkbox"/> Talks in his/her sleep	<input type="checkbox"/> Sleeps with parents
	<input type="checkbox"/> Grinds teeth	<input type="checkbox"/> Trouble getting to sleep	<input type="checkbox"/> Difficult to get to bed
<b>Social Behavior and Relationships</b>	Sleeps in the room with:		
	<b>Personality:</b>		
	<input type="checkbox"/> Friendly	<input type="checkbox"/> Shy	<input type="checkbox"/> Imaginative
	<input type="checkbox"/> Passive	<input type="checkbox"/> Leader	<input type="checkbox"/> Follower
	<input type="checkbox"/> Easily influenced by others	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Under reacts to events
	<input type="checkbox"/> Can entertain self	<input type="checkbox"/> Needs to be given activities	<input type="checkbox"/> Affectionate
	<input type="checkbox"/> Doesn't like hugs/physical contact.		<input type="checkbox"/> Other:
	<b>Social Relationships:</b>		
	<input type="checkbox"/> Prefers younger friends	<input type="checkbox"/> Plays with older children	<input type="checkbox"/> Plays best with one student
	<input type="checkbox"/> Interacts mostly with adults	<input type="checkbox"/> Able to work out conflicts	<input type="checkbox"/> Needs help working out conflicts
	<input type="checkbox"/> Aggressive with friends	<input type="checkbox"/> Doesn't have friends	<input type="checkbox"/> Plays well with a group
	<b>Family History and Dynamics</b>	<input type="checkbox"/> Other:	
<b>Family Relationships:</b>			
<input type="checkbox"/> Gets along well with brothers		<input type="checkbox"/> Doesn't get along well with brothers	<input type="checkbox"/> Good relationship with dad
<input type="checkbox"/> Gets along well with sisters		<input type="checkbox"/> Doesn't get along well with sisters	<input type="checkbox"/> Good relationship with mom
Presently having a difficult time getting along with: <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other:			
Confides in: <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other:			
<b>Family Activities:</b>			
<input type="checkbox"/> Able to spend time together on weekends		<input type="checkbox"/> Watches TV together	
<input type="checkbox"/> Eats meals together: <input type="checkbox"/> breakfast <input type="checkbox"/> lunch		<input type="checkbox"/> Student would rather spend time with friends	
<input type="checkbox"/> Currently having a hard time finding time to spend together		<input type="checkbox"/> Other	
<b>Discipline:</b>			
<input type="checkbox"/> Easy to discipline		<input type="checkbox"/> Hard to discipline	
<input type="checkbox"/> Mother disciplines		<input type="checkbox"/> Father disciplines	
<input type="checkbox"/> Presently having a difficult time finding an effective form of discipline.			
<b>Methods of discipline:</b>			
<input type="checkbox"/> Sent to room		<input type="checkbox"/> Privileges taken away	<input type="checkbox"/> Spanking
<input type="checkbox"/> No TV		<input type="checkbox"/> Talked to	<input type="checkbox"/> Nothing seems to work
<input type="checkbox"/> Other:			
<b>Chores:</b>			
What are your student's chores:			
<input type="checkbox"/> Doesn't have any chores	<input type="checkbox"/> Doesn't follow through on chores	<input type="checkbox"/> Very responsible with chores	
<b>Types of Rewards your Student Likes:</b>			
<input type="checkbox"/> Food	<input type="checkbox"/> Time with parents	<input type="checkbox"/> Going someplace special	

	<input type="checkbox"/> Play time	<input type="checkbox"/> TV	<input type="checkbox"/> Video Games
	<input type="checkbox"/> Stickers	<input type="checkbox"/> Other:	
	<b>Favorite Activities</b>		
	<input type="checkbox"/> Playing outside	<input type="checkbox"/> Playing board games	<input type="checkbox"/> Having friends over
	<input type="checkbox"/> TV	<input type="checkbox"/> Video games	<input type="checkbox"/> Reading
	<input type="checkbox"/> Eating	<input type="checkbox"/> Doing something with parent(s)	<input type="checkbox"/> Playing by him/her self
	<input type="checkbox"/> Sports, which ones?		
	<input type="checkbox"/> Plays on sports team(s), which ones?		
	<b>Traumatic Experiences</b>		
	<input type="checkbox"/> Death of a family member, who?		
	<input type="checkbox"/> Divorce of parents, when?		
	<input type="checkbox"/> Witnessed violence – please describe:		
	<input type="checkbox"/> Emotional trauma – please describe:		
	<b>Health History and Relevant Data</b>	<b>Medically Diagnosed Illnesses:</b>	
<input type="checkbox"/> Chicken pox		<input type="checkbox"/> Convulsions	<input type="checkbox"/> High fevers
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Frequent headaches		<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Seizures
<input type="checkbox"/> Ear infections, what ages?		<input type="checkbox"/> Tubes in ears	
<input type="checkbox"/> Allergies to:			
<input type="checkbox"/> Other:			
<b>Accidents:</b>			
<input type="checkbox"/> Head injury, please describe:			
<input type="checkbox"/> Other accidents, please describe:			
<input type="checkbox"/> Surgeries/Operations, please describe:			
<input type="checkbox"/> Prescription Medication		<input type="checkbox"/> Past:	<input type="checkbox"/> Current:
Does your student experience stomach aches before school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your student experience headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your student experience facial twitches? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Age at last physical exam:		Age at last dental exam:	
Does your student wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, wears glasses for			
<input type="checkbox"/> nearsightedness (can't see objects far away)			
<input type="checkbox"/> farsightedness (can't see objects up close)			
<b>Parent Input</b>	What are your student's strengths?		
	What are your greatest concerns about your student?		
<b>Form completed by:</b>		<b>Relationship to student:</b>	