SOUTHGATE COMMUNITY SCHOOL DISTRICT
SPECIAL EDUCATION DEPARTMENT
PARENT INPUT FORM

Student's Name_____ Birthdate_____

Address_____ Phone_____

School_____ Grade_____ Teacher_____

State your concerns for your child_____

_____

Previous schools attended and dates_____

Did your child attend preschool? ☐Yes ☐No If yes, where?_____

List any special ed. services your child has received_____

FAMILY INFORMATION

Mother's Name_____ Father's Name_____

Who does the child live with_____

Brothers/Sisters-Names and Ages_____

Date of any parent separation or divorce_____

Name of any Step-Parent/Significant Other in the home_____

MEDICAL INFORMATION

Birth History: ☐Premature ☐Full-Term ☐C-Section Birth Weight_____

List any complications during pregnancy or delivery_____

_____

Age the child was: Crawling_____ Walking_____

Talking_____ Toilet Trained: Bladder_____ Bowel_____

List any health problems the child has been treated for_____

_____

List any counseling/therapy services present or past_____

_____

List any hospitalizations (including psychiatric)_____

_____

List any medications takes currently_____

List any problems with sleeping_____

List any problems with eating habits_____

Date of last physical_____ Date vision last checked_____

Date hearing last checked_____ Does your child wear glasses? ☐Yes ☐No

PERSONALITY INFORMATION

Check the following that describe your child most of the time:

- ☐ Friendly
- ☐ Overactive
- ☐ Cooperative
- ☐ Overly Sensitive
- ☐ Disorganized
- ☐ Shares Easily
- ☐ Outgoing
- ☐ Sad/Unhappy
- ☐ Sense of Humor
- ☐ Aggressive
- ☐ Happy
- ☐ Fearful
- ☐ Likeable
- ☐ Calm
- ☐ Defiant
- ☐ Kind
- ☐ Anxious

EXPERIENCES

Check any of the following your child has experienced:

- ☐ Accident Prone
- ☐ Allergic Reactions
- ☐ Blackouts
- ☐ Bedwetting
- ☐ Soiling
- ☐ Hospitalizations-Where?___
- ☐ Hearing Problems
- ☐ Severe Headaches
- ☐ Seizures
- ☐ Frequent Colds
- ☐ Frequent Ear Infections
- ☐ Surgery-Type?_____
- ☐ Vision Problems
- ☐ Dizziness
- ☐ Tremors
- ☐ Head Injury
- ☐ Lead Poisoning
- ☐ Outside Counseling-Where?_____

FAMILY

- ☐ Death of a Relative
- ☐ Death of a Sibling
- ☐ Parent Separation/Divorce
- ☐ Death of a Parent
- ☐ Parent Loss of Job
- ☐ Stepchildren in Home
- ☐ Family Move
- ☐ Stepparent in Home
- ☐ People In/Out of House
- ☐ Individual or Family History of Substance/Alcohol Abuse

PERSONAL

- ☐ Crying Spells
- ☐ Nightmares
- ☐ Friendship Problems
- ☐ Temper Tantrums
- ☐ Restless Sleep
- ☐ Overeating
- ☐ Vomiting
- ☐ Outbursts

DIFFICULTIES

Check any of the following your child has had trouble with:

- ☐ Remembering Things
- ☐ Completing Tasks
- ☐ Getting Along with Others
- ☐ Withdrawing
- ☐ Problems with Police
- ☐ Paying Attention
- ☐ Speech Problems
- ☐ Completing Homework
- ☐ Making/Keeping Friends
- ☐ Destructive Behavior
- ☐ Cheating
- ☐ Acting Without Thinking
- ☐ Academic Work
- ☐ Following Rules
- ☐ Stealing
- ☐ Aggressive Behavior
- ☐ Lying
- ☐ Stuttering

Any additional comments_____

_____

_____

Forms completed by_____ Date_____

Relationship to Student_____

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