Grants Pass School District 7

Parent Information/Developmental History

Student's name: _____ Student's birthdate: _____

Your name: _____ Date completed: _____

Your relationship to student: _____

1. What are your child's strengths and interests?

2. What are your current concerns for your child if any?

3. How long have these concerns existed? Please describe the history of the problem:

4. Please list any significant or stressful events in your child's life within the last several years (moves, divorce, death, etc.):

5. Please list the people who currently live in your home:

6. History of problems/concerns in the family (learning challenges, mental health issues, drug/alcohol challenges, etc.):

7. Have you or any biological family member struggled with reading, writing or spelling?

8. Pregnancy/labor/delivery (complications, medical concerns, premature baby, problems at birth, use of tobacco/alcohol/drugs during pregnancy, etc.):

9. Significant medical history of child (please check if applicable and describe):
____hospitalizations: _____
____surgeries: _____
____accidents/injuries: _____
____prolonged or high fevers: _____
____ear infections: _____
____ear tubes: _____
____asthma: _____
____allergies: _____
____seizures: _____
____tics/twitches: _____
____sleeping or eating problems: _____
____toileting problems: _____
____chronic illness: _____
____other medical concerns: _____

10. Is your child currently on medication? If so, please indicate name, purpose, and dosage:

11. Date of last physical exam:

12. Has your child had exams for hearing and vision? If so, were there any concerns?

13. Developmental Milestones, approximate age that child:

crawled _____ said single words _____ was toilet trained _____

walked _____ put words together _____ stayed dry at night _____