DAYTON INDEPENDENT SCHOOLS
SOCIAL/DEVELOPMENTAL HISTORY

Student's Name: _____ Date of Birth: _____ Date: _____

Name of person filling out form: _____ Relationship to student: _____

School: _____ Grade: _____

Dates Updated: _____ _____ _____ _____

Student lives with (check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster parent
☐ Grandparent ☐ Other: (specify) _____

If the child does not live with both parents, how often does the child see the parent with whom he or she does not reside?

_____

Other people living in the home:

Name	Age	Male/Female	Relationship to student
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

School History

Before beginning kindergarten, did your child attend: ☐ Preschool ☐ Day care ☐ Head Start

If your child attended schools other than those in the Owensboro Public Schools District, please list the schools (city, state) and dates attended: _____

Has your child repeated a grade? ☐ Yes ☐ No (If yes, indicate the grade.) _____

Please check with describes your child's feelings about school:

☐ Likes school ☐ Eager/Motivated ☐ Fearful/Anxious ☐ Dislikes school

Do you have concerns about your child's school progress (e.g., academic, social, behavioral)? ☐ Yes ☐ No

(Please describe) _____

Early Development

Was the child born full-term? ☐ Yes ☐ No (If not, how many weeks was the pregnancy?) _____

Was the child adopted? ☐ Yes ☐ No (If yes, how old was the child when adopted?) _____

Did the mother experience any of the following during this pregnancy?

☐ Serious illness or injury? (Specify:) _____ ☐ Alcohol or other drug use

☐ Other: _____

Did your child experience any of the following difficulties during delivery?

☐ C-section delivery ☐ Low birth weight ☐ Delivered with cord around neck
☐ Jaundice ☐ Cyanosis (turned blue) ☐ Needed oxygen
☐ Seizures ☐ Birth defect (Specify): _____
☐ Injury (Specify): _____ ☐ Other: _____

How was your child's temperament (e.g., happy, cuddly, fussy, colicky) as a baby? _____

Please circle when your child reached developmental milestones*:

Sitting:	Early (3-6 mos.)	Average (7-12 mos.)	Late (over 1 yr.)	Don't know
Walking:	Early (7-12 mos.)	Average (12-18 mos.)	Late (over 18 mos.)	Don't know
Speaking two- to three-word sentences:	Early (9-17 mos.)	Average (18-24 mos.)	Late (over 2 yrs.)	Don't know
Toileting:	Early (1-2 yrs.)	Average (2-3 yrs.)	Late (over 3 yrs.)	Don't know

**Age range information from Centers for Disease Control and Prevention (CDC)*

Has your child received any early intervention services (e.g., First Steps)? ☐ Yes ☐ No

Which of the following? ☐ Speech therapy ☐ Occupational therapy (OT) ☐ Physical therapy (PT)
☐ Developmental intervention (DI) ☐ Other: _____

Health and Wellness

Does the family have a history of any of the following?
☐ Alcohol or other drug use ☐ Anxiety disorder ☐ Depression ☐ Bipolar disorder
☐ Autism ☐ Learning/Reading problems ☐ Behavioral difficulties ☐ Other: _____
☐ Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

The child's overall health is: ☐ Good ☐ Fair ☐ Poor

How many hours of sleep does your child get a night? _____

Does your child currently have any problems sleeping? ☐ Yes ☐ No (If yes, specify below.)
☐ Difficulty falling asleep ☐ Wakes too early ☐ Nightmares ☐ Loud snoring
☐ Awakens during night ☐ Restless sleeper ☐ Sleep apnea ☐ Bedwetting

Does your child have a pediatrician/primary care provider? ☐ Yes ☐ No Doctor's name: _____

When was your child's last checkup? _____ Any significant findings? ☐ Yes ☐ No
(If yes, please explain) _____

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

At any time has your child had the following? (Mark "C" if current problem, "P" if previous but not ongoing.)
____ Asthma ____ Allergies (Specify): _____
____ Epilepsy or seizure disorder ____ Febrile seizures (due to fever) ____ High fevers (over 103°F)
____ Head injury with loss of consciousness ____ Lead poisoning ____ Chronic ear infections/Tubes in ears
____ Diabetes ____ Other ongoing health problems: _____
____ Vision problems (describe): _____

Have glasses or contacts been prescribed? ☐ Yes ☐ No Does your child wear them? _____

____ Hearing problems (describe): _____

Does your child wear a hearing aid? ☐ Yes ☐ No

Does your child have any other medical diagnoses (physical or mental)? ☐ Yes ☐ No (If yes, please explain) _____

_____

Has your child been hospitalized for medical treatment? ☐ Yes ☐ No
When? _____ Why? _____ Hospital: _____

Has your child had a psychological evaluation outside of school? ☐ Yes ☐ No
When? _____ Why? _____ Agency: _____
**These hospitals and agencies will not be contacted unless you have signed an Authorization to Disclose Information Form. Your child's records are protected.*

Home and Community

What is the primary language spoken by the parents? _____ by the child? _____

How does your child spend time outside of school?
☐ Reading/Being read to ☐ Playing outside ☐ Using the computer ☐ Using the phone
☐ Spending time with family members or friends ☐ Working at a job ☐ Doing homework ☐ Watching TV
☐ Playing with toys or non-electronic games ☐ Playing video games ☐ Other: _____

How are your child's relationships with the following? (*Specify good/fair/poor*.)
Parents: _____ Other adults: _____ Siblings: _____ Peers: _____

What are your child's regular chores/household responsibilities? _____

_____

What forms of discipline and behavior management are used with your child? Check all that apply.
☐ Time-out ☐ Behavior chart/rewards system ☐ Spanking
☐ Loss of privileges ☐ Grounding ☐ Extra privileges
☐ Other (please describe): _____

How does your child usually react to discipline? ☐ Complies ☐ Complains ☐ Does not comply and resists
☐ Indifferent or passive attitude ☐ Other: _____

Has your child experienced any of the following stressful events that have impacted the child's academic/social development? (Check if applicable)
☐ Parents divorced or separated ☐ Student changed schools ☐ Parent changed or lost job
☐ Family accident or illness ☐ Family moved ☐ Family financial problems
☐ Custody change ☐ Homelessness
☐ Death in family _____
☐ Addition of family member _____
☐ Other (please describe): _____