

DAYTON INDEPENDENT SCHOOLS
SOCIAL-DEVELOPMENTAL HISTORY UPDATE
(FOR RE-EVALUATION PURPOSES ONLY)

EC #16

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

School: _____ 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?

School History

Please check which 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) _____

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: _____

Date of last check-up: _____ Does your child have any medical diagnoses (physical or mental)? Yes No
(If yes, please explain) _____

Is your child prescribed medication? Yes No (If yes, please list all medications/dosages)

Have glasses or contacts been prescribed? Yes No Does your child have hearing problems? Yes No

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.

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 Other (please describe): _____
 Death in family Addition of family member _____