COMMITTEE ON SPECIAL EDUCATION
SOCIAL HISTORY

Child's Name _____ DOB _____ Sex ____ School _____ Grade _____

Address _____ Phone _____

Information Provided By _____ Relationship to Child _____ Interviewer _____ Date _____

PARENTS

Father's Name _____ Age _____ Highest Grade Completed _____

Address _____ Home Phone _____ Cell _____

Employer _____ Occupation _____ Work Phone _____ How Long _____

Email Address

Mother's Name _____ Age _____ Highest Grade Completed _____

Address _____ Home Phone _____ Cell _____

Employer _____ Occupation _____ Work Phone _____ How Long _____

Email Address

Are parents living together: ☐ Yes ☐ No

If **NO**, is this due to: ☐ Death ☐ Divorce ☐ Separation ☐ Other

With whom does child live: _____

Who is the legal guardian: _____

How often does child see other parent: ☐ Every week ☐ Once/twice a month ☐ Other: _____

Does child have stepparents: ☐ No ☐ Yes: Name & Phone #: _____

Other adults living with child: _____

Language spoken at ***home***: _____

Other languages spoken: _____

Primary language of ***child***: _____

BROTHERS / SISTERS

List brothers, sisters and any other children living with the family:

Name(s)	***DOB***	***Sex***	***Relationship to this child***

CAREGIVERS

Does child use a baby-sitter, day care or after school program on a regular basis: ☐ No ☐ Yes If **yes**, details:

Name _____ Phone _____ Language/s Spoken _____

REFERRAL INFORMATION

Why is child being referred for an evaluation: _____

What do you see as child's main difficulty: _____

When did these problems begin: _____

Has child ever been in a special education program or received any remedial services or tutoring: _____

Do any members of the family have a disability? *(physical, hearing, emotional etc.)* Explain: _____

Are there any problems in the home or community that might be affecting the child's performance in school: _____

Is there anything else you think is important for us to know regarding this child or his/her education: _____

DEVELOPMENTAL / MEDICAL HISTORY

BIRTH / PREGNANCY

1. When child was born: Mother's age: _____ Father's age: _____
2. Was mother under a doctor's care: ☐ Yes ☐ No
   Were there any problems during pregnancy: ☐ No ☐ Yes
   Was mother taking medication: ☐ No ☐ Yes
3. Was the baby: ☐ Full-term ☐ Premature ☐ Overdue
   Length of labor:
   Was anesthesia used: ☐ No ☐ Yes
   What kind of delivery: ☐ Breech ☐ Cesarean ☐ Natural ☐ Forceps ☐ Induced
   Was anesthesia used: ☐ No ☐ Yes
   Baby's birth weight: _____
4. Complications for infant during/after delivery: _____
5. Did mother care for baby after birth: ☐ Yes ☐ No
   If **NO**, name and relationship of person who cared for baby: _____
6. Feeding/sleeping problems during infancy: _____
7. Other significant events you feel are important: _____

DEVELOPMENT

Developmental Milestones - *At what age did child:*

Crawl _____
Walk _____
Talk _____
Toilet Train _____

Any speech difficulties: ☐ No ☐ Yes: _____
Has child been in speech therapy: ☐ No ☐ Yes
Any problems with wetting / soiling: ☐ No ☐ Yes: _____
Medical reasons for bed wetting / soiling: ☐ No ☐ Yes: _____

MEDICAL HISTORY

If yes, provide details and dates:

Any hospitalizations or serious illnesses: ☐ No ☐ Yes: _____
Ear problems and/or infections: ☐ No ☐ Yes: _____
Ear tubes: ☐ No ☐ Yes: _____
Audiological Evaluation: ☐ No ☐ Yes: _____
Vision Problems: ☐ No ☐ Yes: _____
Glasses / Contacts: ☐ No ☐ Yes: _____
Physical problems *(i.e.: allergies, stomach aches, walking, etc.):* _____
Has child ever had a convulsion or seizure: ☐ No ☐ Yes: *When:* _____
If **YES**, has child seen a neurologist: ☐ No ☐ Yes: *When:* _____
Medication taken regularly in last 12 months: ☐ No ☐ Yes: _____
If **YES**, provide details: _____
Ever taken medication to decrease activity level: ☐ No ☐ Yes: _____
Where is child taken for his/her medical care: Name _____ Phone # _____

SCHOOL HISTORY

PRESCHOOL

Did child attend: ☐ Day Care ☐ Play Group ☐ Nursery School

At age: _____ Name of School/Provider: _____

Did child have problems:

Separating from parent/caregiver: ☐ No ☐ Yes

With routines/discipline: ☐ No ☐ Yes

With academic demands: ☐ No ☐ Yes

If **yes to any of the above**, describe: _____

Did either you or the teacher have concerns about child's progress or adjustment: ***Which***: _____

Explain concerns: _____

KINDERGARTEN

Where: _____ Age *(as of Sept 1st. of the year started Kgtn.)*: _____

Did child have problems:

Separating from parent/caregiver: ☐ No ☐ Yes

With routines/discipline: ☐ No ☐ Yes

With academic demands: ☐ No ☐ Yes

If **yes to any of the above**, describe: _____

Did either you or the teacher have concerns about child's progress or adjustment: ***Which***: _____

Explain concerns: _____

1ST THROUGH 5TH GRADE

List all schools and/or districts child attended: _____

Did child repeat a grade: ☐ No ☐ Yes: *Indicate Grade(s) repeated* _____

Child's performance: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Child's feelings about school: ☐ Eager to go ☐ Dislikes ☐ Tries to avoid

Other comments: _____

Any problems brought to your attention *(academic/social)*: _____

What was done: _____

Describe homework habits/attitude: _____

6TH THROUGH 8TH GRADE

List all schools and/or districts child attended: _____

Child's performance: ☐ Excellent ☐ Good ☐ Average ☐ Poor

What subjects presented the most difficulty: _____

Any problems brought to your attention *(academic/social)*: _____

What was done: _____

Describe homework habits/attitude: _____

Was there a change in child's attitude or performance: _____

9TH THROUGH 12TH GRADE

List all schools and/or districts child attended: _____

Child's performance: ☐ Excellent ☐ Good ☐ Average ☐ Poor

What subjects presented the most difficulty: _____

Describe child's study habits: _____

Child's post-high school plans: ☐ College ☐ Employment ☐ Vocational Training ☐ Other

Extra-curricular activities: _____

Has there been a change in child's attitude or performance: _____

Does he/she work: ☐ No ☐ Yes: # hours weekly _____

Where: _____ Position: _____

SOCIAL / EMOTIONAL FUNCTIONING

FAMILY / INTERPERSONAL RELATIONSHIPS

1. How would you describe child's personality: *(temperament, behavior, etc.)* _____

_____

2. What do you enjoy most about this child: _____
3. With whom does child get along best in the family: _____

   With whom does he/she have most difficulty: _____
4. Do you have discipline problems or other concerns about the child at this time: _____

_____

5. Describe how child feels about her/himself: _____

_____

6. Has child ever had counseling: ☐ No ☐ Yes: ***At what age:*** _____

   Reason: _____

   Name of Provider: _____ Phone #: _____
7. Has child ever been separated from either parent: ☐ No ☐ Yes

   Dates: _____ Length of separation and cause: _____
8. Has child ever had run away from home: ☐ No ☐ Yes: _____
9. Has child ever been in trouble with the law: ☐ No ☐ Yes: _____

PEER RELATIONSHIPS

Indicate below how this child relates with other children:

Difficulty relating/playing with other children	☐ No	☐ Yes
Fights frequently with peers	☐ No	☐ Yes
Prefers playing with younger children	☐ No	☐ Yes
Has difficulty making friends	☐ No	☐ Yes
Prefers to play/be alone	☐ No	☐ Yes

IF YES TO ANY OF THE ABOVE, provide any pertinent details: _____

_____

Are there children in the neighborhood with whom child could play: ☐ No ☐ Yes

What role does child take with peers/groups *(i.e.: leader, follower, aggressor, victim, etc.):* _____

BEHAVIOR / TEMPERAMENT / INTERESTS

Does child <u>REGULARLY</u> exhibit any of the following?

Short attention span	☐ No	☐ Yes		Overreacts when faced with a problem	☐ No	☐ Yes	
Lack of self control	☐ No	☐ Yes		Requires a lot of parental attention	☐ No	☐ Yes	
Difficulty showing affection	☐ No	☐ Yes		Appears depressed	☐ No	☐ Yes	
Hides feelings	☐ No	☐ Yes		Racing thoughts / talking too fast	☐ No	☐ Yes	
Has fears	☐ No	☐ Yes		Sleeping difficulties	☐ No	☐ Yes	
Very active / hyperactive	☐ No	☐ Yes		Drug Use suspected	☐ No	☐ Yes	
Impulsive	☐ No	☐ Yes					

If **yes to any of the above**, explain: _____

_____

What activities does child enjoy *(Sports/Hobbies/Interests/Talents)*: _____

Have you noticed any change in child's interest in participating in these activities recently? If yes, describe: _____

_____

TESTING / EVALUATION / SERVICES - Has child ever had the following:

	✓ if Yes	***Date(s)***	***Provider***	***City, State***	***Phone #***
Neurological Exam	☐				
Psychiatric Exam	☐				
Psychological	☐				
Audiological Eval *(hearing)*	☐				
Counseling	☐				
Speech/Language Services	☐				
Tutoring	☐				

It is helpful for us to receive information from other professionals who have worked with your child. Please consider letting us contact them. *IF YOU AGREE, PLEASE SIGN THE STATEMENT ON THE NEXT PAGE.*

Nassau BOCES is collecting your phone number for communications purposes. By providing the number(s) and signing this document, you agree that the school may contact you by phone or text, including with auto-dialed and/or prerecorded messages regarding school emergencies, school events and any other school-related communications, as well as other information deemed relevant by Nassau BOCES.

Social History Update

Please complete and return this form as soon as possible.
If you have any questions, contact the social worker or school counselor. Thank you.

Child's Name _____ School _____ Grade _____

Name of Person Completing Form _____ Relationship to Child _____ Date _____

PHONE #: Mother: Home _____ Work _____ Cell _____

Father: Home _____ Work _____ Cell _____

FAMILY: Are child's parents living together: ☐ Yes ☐ No

If **no**, specify: ☐ Divorce ☐ Separation ☐ Death

Who has legal custody: _____

If there has been a death, divorce, or separation in the last 3 years, how has this impacted child's performance in school:

_____

MEDICAL: Has child had any hospitalization or serious illness in the past 3 years: ☐ No ☐ Yes

If **yes**, describe: _____

_____

Where is child taken for his/her medical care: Name _____ Phone # _____

Is child taking any kind of medication: ☐ No ☐ Yes

If **yes**, specify medication and reason for taking: _____

SCHOOL: Describe child's present performance: _____

What subjects is s/he having the most trouble with: _____

What after school activities is s/he involved in:

Organized activities *(i.e.: sports, clubs)*: _____

Hobbies / interests / talents: _____

Describe child's study habits: _____

Describe child's attitude towards school: _____

OTHER: Is there anything else you think is important for us to know regarding this child's education: ☐ No ☐ Yes

If **yes**, explain: _____

_____

Have you noted any significant changes in child, physically or emotionally, in the last 3 years: ☐ No ☐ Yes

If **yes**, explain: _____

SERVICES: Is child currently receiving any services outside of school *(i.e.: tutoring, counseling, speech):* ☐ No ☐ Yes

Type of Service	Name of Provider	Phone #

FOR MIDDLE AND HIGH SCHOOL STUDENTS

WORK: Does child work: ☐ No ☐ Yes Position: _____

If **yes**, where: _____ # Hours Weekly: _____

FOR HIGH SCHOOL STUDENTS

POST-HS: Has student made any plans for the future: Educational: _____

Vocational: _____

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