Date Sent to Parent	Date to be Returned	Sent by	Date Returned to School

ENCINITAS UNION SCHOOL DISTRICT
HEALTH AND DEVELOPMENT HISTORY
(USE ONLY FOR INITIAL EVALUATION)

CONFIDENTIAL

Child's Name _____ Sex _____ Birthdate _____ Age _____
Last First
School _____ Grade _____ Teacher _____

Address _____ Home Phone _____

Cell Phone _____Email _____

Your answers to the following questions will help us to better understand your child. However, any questions may be left unanswered if you wish.

Please answer the following questions. Fill in the indicated blanks or check the items that apply. Feel free to add any explanations or other information along the side. THANK YOU.

Birth Parent	Full Name	Age	Education	Occupation	Place of Birth
Father					
Mother					
Step-Parent					
Father					
Mother					
Adoptive Parent (optional)					
Father					
Mother					
Other					
Father					
Mother					

Please record the names and ages of all family members with whom the child lives. If there are 2 households, list the members of each, and the usual division of the child's time between the two.

Household with Mother	Household with Father (if different)
Name and Relationship Age	Name and Relationship Age
When child is in this household	When child is in this household

Please list in order any evaluations which have previously been done and attach a copy. If this is your only copy, check "Return" so we can copy and return the original to you. If you do not have a copy, please include the address and/or phone number where it was done and sign the **Authorization for Exchange of Information** for request of outside records.

DATE **WHERE (Place or Person)** **TYPE OF EVAULATION** **RETURN**

a) _____

Address/Phone _____

b) _____

Address/Phone _____

c) _____

Address/Phone _____

Please include reports from previous schools. If you are returning this questionnaire to staff at the current school for them to coordinate this evaluation, you do not need to return your copy of any prior evaluations done by this school.

Please list all school attended:

School name and location	Grade(s)	Dates attended

FAMILY HISTORY

Please check any of these which occurred in the child's family (include the child's aunts, uncles, first cousins, grandparents, and great-grandparents, as well as parents, brothers, and sisters.

	Relationship to Child		Relationship to Child
[ ] Diabetes	_____	[ ] Difficulty with academics	_____
[ ] Learning problems	_____	[ ] Deafness	_____
[ ] Drug or Alcohol Abuse	_____	[ ] School Drop-out	_____
[ ] Poor Concentration	_____	[ ] Mood Disorders	_____
[ ] Psychotic Disorders	_____	[ ] Motor or Vocal Tics	_____

Are there special problems in your family, which might worry, anger, or sadden your child? [ ] Yes [ ] No
If "yes", please describe:_____
_____

Have there been any unusual family events, such as:

	YES	NO	Explain "YES" items	Date
Serious illness				
Hospitalizations				
Deaths				
Divorces				
Frequent moves				
Other				

PERINATAL HISTORY

PREGNANCY WITH THIS CHILD:
Any exposure to external agents during pregnancy, such as medications to control nausea, smoking, alcohol…?

Any health problem during this pregnancy, such as vaginal bleeding, high blood pressure, excessive vomiting, infections, weight gain) under 15 lbs. or over 40 lbs., gestational diabetes, injury, …? _____
_____

Any other health concerns, such as too much or too little amniotic fluid, too much or too little fetal activity, sudden change in fetal growth or activity _____

Any concerns with other pregnancies? _____

LABOR AND DELIVERY:
Any illnesses or complications of labor and delivery, such as fever, excessive bleeding, general anesthesia, fetal heart irregularities?
_____

Did the baby have any problems during delivery, such as need for Caesarian, breech, long labor, umbilical cord around neck, knotted, prolapsed?
_____

BIRTH DATA:
Birth Weight _____ Length _____

Born more than a week sooner or later than due (40 weeks)?
[ ] Early (how many weeks? _____)
[ ] Late (how many weeks? _____)

Was newborn in hospital after mother discharged home? [ ] Yes [ ] No
If yes, how long _____, why _____

Diagnosis of maternal post partum depression? [ ] Yes [ ] No If yes, how long_____

Any infant problems in the first weeks at home, such as vomiting, colic, diarrhea, breathing problems, surgery needed?
_____

Feeding problems in infancy, such as difficulty latching, poor eater, poor weight gain?
_____

DEVELOPMENT

Please indicate **age and rate** at which your child achieved the following:

Age	Slow	Average	Fast	
				Smile
				Sit without help
				Crawl on hands and knees
				Walk alone (10-15 steps)
				Feed self
				Demonstrate hand preference (right _____ left _____)
				Speak first words other than mama, dada
				Put two words together
				Speak clearly so strangers understand
				Dry in daytime
				Dry at night
				Separate from parent without crying
				Read words
				Read simple book

MEDICATIONS

Please list any MEDICATIONS which have been prescribed for allergies, seizures, attention, or other CHRONIC problems.

Dates	Name of Medication	Dose/Time of day	Reason and result

HEALTH / MEDICAL CONCERNS

Please check areas that apply to your child.

Frequent and/or significant infections?

[ ] Strep Tonsillitis (total number _____ last infection _____)
[ ] Ear infection (total number _____ number past year _____)
[ ] Sinus infection (total number _____ number past year _____)
[ ] Bronchitis/pneumonia (when _____)
[ ] Meningitis/encephalitis (when _____)
[ ] Tuberculosis (when _____)
[ ] Hepatitis (when _____)
[ ] Mumps (when _____)
[ ] Chicken pox (when _____)
[ ] Whooping cough (when _____)
[ ] Rubella (when _____)
[ ] Measles (when _____)
[ ] Urine infection (total number past year _____ last urine test _____)

HEALTH / MEDICAL CONCERNS (continued)

Please indicate specific problem or condition that affects your child.

Any blood problems?
Such as anemia, low blood counts; requiring blood transfusions, or excessively easy bruising
_____ Date / Age _____ Cause _____

Any general complaints?
Such as leg pains, trouble walking, tires very easily, stuttering, trouble falling asleep, trouble staying asleep, nightmares, or excessive weight gain or loss
Indicate Complaint_____ Onset Date / Age _____ Cause _____

Problems related to the head, nerves, and muscles?
Such as headaches, migraine headaches, loss of consciousness, difficulty with speech, Cerebral palsy, unusual movements (tremor, jerk, twisting), involuntary noises or tics, muscle weakness, or awkward, clumsy, asymmetrical in movements, or significant head injury, dizziness or fainting,
Indicate Problem _____ Onset Date / Age _____
Abnormalities shown on special studies (MRI, CT, EEG, etc.) Study _____ Date _____
If problems with Seizures: How Frequently_____ Type _____
When Occur (Occurred) _____ Describe Seizure _____

Problems with vision or hearing?
[ ] Near sighted [ ] Glasses (when _____)
[ ] Far sighted [ ] Glasses (when _____)
[ ] Strabismus (cross-eyed)
[ ] Astigmatism (Right _____ Left _____)
[ ] Cataract (Right _____ Left _____)
[ ] Nystagmus (dancing eyes)
[ ] Blurred vision
[ ] Hearing problem (hearing aid since what age _____ Right _____ Left _____)

Heart or lung problems? Such as: heart murmur, abnormality of heart rate, congenital heart defect, shortness of breath, turning blue (cyanosis), or stopped breathing
Indicate Problem _____

Urinary or genital problems? Such as bed-wetting or wetting pants, painful or excessively frequent urination, discolored urine/blood in urine, menstrual problems, or undescended testicle
Indicate Problem _____

Abdominal problems? Such as stomach aches, vomiting, nausea, loss of appetite, constipation, stool soiling, hernia, ulcers, appendicitis, or blood in bowel movement
Indicate Problem _____

Any allergies? Specify to what and describe reaction
[ ] Medication allergies (to what _____ describe reaction _____)
[ ] Allergies to other substances (to what _____ describe reaction _____)
If possible anaphylaxis reaction indicate if EpiPen prescribed [ ] Yes [ ] No
[ ] Food intolerance (to what _____ describe reaction _____)
[ ] Insect allergies (to what _____ describe reaction _____)
[ ] Asthma (Inhaler Prescribed [ ] Yes [ ] No (what, when used _____)
[ ] Eczema [ ] Hives [ ] Stuffy nose/itchy eyes (hay fever) [ ] Contact dermatitis (poison oak, ivy)
[ ] Behavioral: Drug allergies _____ Other allergies_____

HEALTH / MEDICAL CONCERNS (continued)

Chronic disease? Such as Sickle Cell disease, Thyroid problem or Diabetes _____)
Cancer (type _____)
Other genetic or metabolic problem or birth defect (what _____)

Any hospitalizations?
[ ] Surgery (what, when _____)
[ ] Other illness (what, when _____)

Any fractures or accidents? [ ] Yes [ ] No (what, when _____
_____

Later feeding concerns? Often puts non-food substances in mouth (what_____)
Gaining too much weight (age _____), Growing too slowly (age _____), Won't eat "healthy" food (age _____), Seems to have behavioral reaction to certain food _____
Known to have swallowed poisonous substance? [ ] Lead_____ [ ] Other _____

EDUCATION "CURRENT" FUNCTIONING

Please check the appropriate items and fill in the blanks indicated.

Preschool and school experience:
[ ] Language other than English spoken in the home (_____)
[ ] Participated in infant stimulation program
[ ] Attended day-care (age _____)
[ ] Attended preschool (age _____)
[ ] Repeated a grade (which _____ why _____)
[ ] Enrolled in special program (when _____ what _____)

Current Functioning – please check the box which best describes your child's functioning.

	Great difficulty	Some difficulty	Does pretty well	Does very well
Overall school performance				
Study habits				
Completing homework				
Remembering assignments				
Interest in school work				
Behavior/feelings				
Overall confidence/self-esteem				
Relationship with brothers/sisters				
Relationship with other children				
Relationship with parents				
Happiness in school				
Worries				
Happiness at home				
Ability to handle frustration				
Willingness to attend school				
Acceptance of responsibilities				
Handwriting				
Getting homework to and from school/class				
Understanding homework				

EDUCATION "CURRENT FUNCTIONING" (continued)

Are you pleased with the program your child now has in school? [ ] Yes [ ] No [ ] Not sure

How would you like school services for your child to change? _____

_____

_____

_____

_____

_____ _____

Signature of person completing form Date

_____

Relationship to child

Revised April 2013