WAKE COUNTY
PUBLIC SCHOOL SYSTEM

Social and Developmental History

This information is a required component for special education decision-making.
It will be maintained in the student's confidential records.

A. Family Information

Date Form Completed_____

Child's Name _____ **Date of Birth**_____

Name of Person Completing this Form_____

Phone: _____ **E-Mail:** _____

Relationship to Child_____

Please list all people in the child's family:

Name	Relationship to Child	Age	Living in Household?

Please list all other people living in the child's household:

Name	Relationship to Child	Name	Relationship to Child

Are there any issues you would like to make us aware of? (Check all that apply)

□ Separation of parents
□ Divorce of parents
□ Remarriage/New parental relationship
□ Family health issue
□ Death of loved one
□ Increased tension in the home
□ New baby
□ Recent move
□ Loss of job
□ Traumatic event
□ Other: _____

If checked, explain: _____

_____

Has this issue had a significant impact on the child? □ Yes □ No

If yes, explain: _____
_____
_____

Are there other adults who have a significant part in raising the child?

_____
_____

Does your child have difficulty getting along with any family member?

□ Yes □ No

If yes, explain: _____
_____

B. Prenatal/Birth History

1. Is child your:

□Biological child
□Adopted child
□Foster child
□Other _____

2. Mothers age at time of child's birth: _____

3. Did mother receive prenatal care?

□ Yes □ No □ I don't know

4. Did mother experience any of the following during pregnancy?

□ I don't know
□ Alcohol/drug use
□ Car accident
□ Diabetes
□ Emotional stress
□ Excessive bleeding
□ Falls
□ Hypertension
□ Nicotine use
□ Physical injury
□ Prescription drug use:_____
□ Other:_____

5. Length of Pregnancy: _____

6. Length of Labor and Delivery: _____
_____

7. Location of birth:

□ Home
□ Hospital
□ Other: _____
_____

8. Birth weight: _____

9. Were there any complications during delivery?

□ I don't know
□ No
□ Anoxia (lack of oxygen)
□ Cesarean
□ Cord around neck
□ Drop in heart rate
□ Use of forceps
□ Other: _____
_____

10. What was your child's condition immediately after birth?

□ I don't know
□ Healthy
□ Critical (placed in NICU)
□ Difficulty breathing
□ Jaundice
□ Placed in incubator
□ Seizures
□ Other: _____
_____

11. How long was your child in the hospital after delivery? _____
_____

C. Infancy/Early Development

1. In general, how would you describe your child's early gross motor skill development (e.g., sitting up, crawling, standing, walking)? Choose one.

□ I don't know
□ Earlier than most children
□ Typical compared to other children
□ Later than most children
If later:
Age of sitting:_____
Age of crawling:_____
Age of walking: _____

2. In general, how would you describe your child's fine motor skill development (e.g., grasping objects, scribbling, buttoning, coloring)? Choose one.

□ I don't know
□ Earlier than most children
□ Typical compared to other children
□ Later than most children
If later, explain: _____
_____

3. In general, how would you rate your child's language development (e.g., babbling, first words, speaking in sentences)? Choose one.

□ I don't know
□ Earlier than most children
□ Typical compared to other children
□ Later than most children
If later:
Age of first words:_____
Age of sentence use:_____

4. Did your child receive routine immunizations?

□ Yes
□ No
Comments: _____
_____

5. How would you describe your child's temperament/mood from birth to age 1? Check three that best describe your child as an infant.

□ Active	□ Fearful
□ Adaptable	□ Irritable
□ Approachable	□ Loving
□ Colicky	□ Playful
□ Curious	□ Predictable
□ Demanding	□ Shy
□ Distractible	□ Sociable
□ Easygoing	□ Withdrawn

□ Other _____

6. During infancy (Birth to age 1), did your child experience any of the following health issues?

□ Frequent ear infections
□ Hearing problems
□ High Fevers
□ Seizures
□ Vision problems
□ Other_____
If checked, explain:
_____
_____
_____
_____
□ Any hospitalizations – Please specify:
_____
_____
_____
_____

D. Toddler/Preschool Years

1. Did your child receive regular care from others? Choose all that apply:

- □ I don't know
- □ Baby sitter/Nanny:
  - □ In your home
  - □ Outside the home
- □ Relative/Friend:
  - □ In your home
  - □ Outside the home
- □ Day Care/Child Care Center
- □ No

2. Did your child attend preschool? Choose one.

- □ Yes
- □ No

If yes,

Name _____

How long? _____

How frequently? _____

3. During toddler/preschool years, how would you rate your child's social development (play skills, interactions with familiar or unfamiliar adults or children)? Choose one.

- □ Overly social
- □ Typically social
- □ Difficulty with socializing; explain: _____

_____

_____

- □ I don't know

4. During toddler/preschool years, how would you rate your child's behavioral regulation (anger management, activity level, self-restraint)? Choose one.

- □ Managed behavior easily
- □ Typical
- □ Difficulty with behavior
- □ Extreme difficulty; explain: _____

_____

- □ I don't know
- □ N/A

5. During toddler/preschool years, how would you rate your child's self-care (dressing, feeding, grooming, toileting)? Choose one.

- □ Advanced
- □ Typical
- □ Delayed; explain: _____

_____

- □ I don't know
- □ N/A

6. During toddler/preschool years, how would you rate your child's acquisition of basic academic skills (Shapes, colors, counting, numbers, letters, rhymes, songs)? Choose one.

- □ Advanced
- □ Typical
- □ Delayed; explain**:** _____

_____

- □ I don't know
- □ N/A

E. Medical Concerns

1. What is your child's overall physical health?

- □ Excellent
- □ Good
- □ Fair
- □ Poor

4. Is your child currently taking any medication?

□Yes □ No

If yes, please list medications and uses:

_____

_____

_____

2. Has your child had any of the following?

Check all that apply:	If yes, describe with dates and/or age of onset
□ Allergies and or/asthma	
□ Bedwetting	
□ Diabetes	
□ Ear infections	
□ Hearing Problems	
□ Serious Illness	
□ Seizures/ Convulsions	
□ Sickle Cell	
□ Vision Problems	
□ Other Health Problems	

Comments: _____
_____

3. Does your child have any diagnosed medical/mental health conditions?

□Yes □ No
If yes, explain:
_____
_____

5. Has your child ever sustained a head injury?

□Yes □ No □I don't know

Was medical attention/hospitalization required?
□I don't know
□No
□Yes
If yes, explain: _____
_____
_____

How long ago did the injury occur?
□Within the past year
□1 to 2 years ago
□3 to 4 years ago
□More than 5 years ago

Was your child unconscious?
□I don't know
□No
□Yes, for how long?_____
_____

F. Current Behavior and Social Development

1. Please check all the behaviors or characteristics that describe your child over the past year:

□ Aggressiveness
□ Anxiousness
□ Eating Issues
□ Disorganization
□ Distractibility
□ Impulsiveness
□ Inattentiveness
□ Overactivity
□ Repetitive/ Compulsive Behaviors
□ Sleeping Issues
□ Uncooperative
□ Withdrawal
□ Other Behaviors of Concern: _____
_____

2. Does your child have friends other than family members?

□ Has many friends
□ Has some friends
□ Has not made any friends

3. What are the most effective ways to discipline your child?
_____
_____
_____
_____

4. What are the most effective ways to reward your child?
_____
_____
_____
_____

5. What are your child's favorite activities outside of school?
_____
_____
_____

G. Parent Perspective

1. When did your child's difficulties begin and how long have they been ongoing?

_____
_____
_____

2. Has your child ever had an academic or psychological evaluation?

□ Yes □ No □ I don't know

If yes, explain: _____
_____
_____
_____

3. Has your child ever received any form of special services?

□ Counseling
□ Sensory Integration Therapy
□ Occupational Therapy
□ Special Education
□ Physical Therapy
□ Speech Therapy
□ Other: _____

If checked, explain: _____
_____
_____

Name of Provider/Agency: _____
_____

4. Have his/her sibling(s) experienced social or academic difficulties?

□ Yes □ No □ I don't know

If yes, explain: _____
_____
_____
_____

5. Did either of the birth parents experience similar difficulties as a child?

□ Yes □ No □ I don't know

If yes, explain: _____
_____
_____
_____

6. Have other teachers or caregivers of your child reported any difficulties or concerns with his/her learning, behavior, speech, etc.?

_____
_____
_____
_____

7. Please describe your child's strengths:

_____
_____
_____
_____
_____

8. In your words, how do you describe your child's difficulties in school?

_____
_____
_____
_____
_____

9. Is there any other information you would like to share? _____
_____
_____
_____

10. Are there any questions you have that we can answer? _____
_____
_____
_____

11. Would you like to speak with someone about the information you have shared?

□ Yes □ No

What is the best way to contact you? _____
_____
_____

Only complete this last section if the primary language spoken at home is a language other than English

H. Supplemental questions for students with a language other than English spoken in the home

1. What is your child's native language?
_____

2. What language does your child prefer to speak at home?_____

3. What language does your child prefer to speak at school?_____

4. Can your child engage in a conversation in the language spoken at home?_____

5. How long has your child lived in the U.S.?
- □ Born in the U.S.
- □ 0-6 months
- □ 6-12 months
- □ 1-2 years
- □ 3-4 years
- □ 5-6 years
- □ 7-8 years
- □ 9 or more years

6. Has your child lived apart from you?
- □ Yes
- □ No

If yes, for how long?_____

7. What is the father's country of origin?_____
Mother's country of origin? _____

8. Does anyone in the family speak English?
- □ Yes
- □ No

If yes, who? _____

9. Does anyone in the family read?
- □ English
- □ Native language

If yes, who? _____

10. What previous educational experiences has your child had in the native language?
- □ None
- □ Preschool
- □ Elementary – last grade attended_____
- □ Secondary – last grade attended_____
- □ Interrupted educational experiences please explain_____
  _____
  _____

11. Can your child read and write in the native language?
- □ Yes
- □ No

If yes, please indicate his or her levels (if known)? _____
_____

12. If your child attended school in another country or territory, did any of his/her teachers indicate to you that they thought he/she had learning problems?
- □ Yes
- □ No

If you answered yes, what did they tell you about your child's learning issues?_____
_____
_____
_____
_____
_____

13. What language does your child prefer to watch TV or listen to music?
_____