DANSVILLE CENTRAL SCHOOLS
SOCIAL HISTORY

Student: ______________________________ Date of birth:___________Today's date:__________
Student's Ethnic Group: ___African American, ___American Indian, ___Asian, ___Hispanic,
___Native Hawaiian/Other Pacific Islander, ___White
Person Providing Information: ________________________ relationship:____________________
School:________________________ grade: ___________ teacher:_________________________
School Psychologist's Signature: ____

GENERAL INFORMATION:

Mother's name including maiden name:______________________________ Stepmother? Yes No
Address:____ Home phone: ___________
Occupation: __________________ Work phone: ______________ Employer: ________________
Highest grade completed:____________________
Dominant Language English? Yes No If no, what is your dominant language? ____________

Father's name:______________________________ Stepfather? Yes No
Address:____ Home phone: ___________
Occupation: __________________ Work phone: ______________ Employer: ________________
Highest grade completed:____________________
Dominant Language English? Yes No If no, what is your dominant language? ____________

With whom does the child live? ____
Who has legal custody?____

Does the child have other parent(s)/stepparent(s)? Yes No
If yes, please provide the following information:
Name: ___________________________ Relationship to child: _____________________________
Address: _________________________________ Home phone: ______________________________
Occupation: ____

Name: ___________________________ Relationship to child: _____________________________
Address: _________________________________ Home phone: ______________________________
Occupation: ____

Please list all brothers/sisters or others living with the family:

Name of sibling/other persons	Sex	Date of Birth	Relationship to Child	Living at Home?

FAMILY HEALTH

Has ***this child*** had any of the following? If yes, please indicate with child's name. Have any **family members** had any of the following? If yes, please specify family member's relationship to the child. If the child is not living with the biological parents/siblings, please include health information if known.

Attention Deficit Disorder:______________________________
Attention Deficit Hyperactivity Disorder ______________________________
Hearing Loss______________________________
Respiratory Problems ______________________________
Asthma ______________________________
Diabetes______________________________
Seizures______________________________
Heart problems______________________________
Depression ______________________________
Anxiety Disorder ______________________________
Alcoholism ______________________________
Drug Abuse______________________________
Cancer ______________________________
Learning Disability______________________________
Speech/Language Problem______________________________
Other (including but not limited to: autism, cystic fibrosis, multiple sclerosis, physical handicap, alzheimer's disease, muscular dystrophy, tourette's syndrome, cerebral palsy, mental retardation, other mental illness)
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____
____
____

Please note whether your child has had any of the following:

Head injuries______________
Loss of consciousness______________
Migraines______________
Bronchitis______________
Pneumonia______________
Allergies ______________
Intolerances______________
Sinus problems ______________
Frequent colds ______________

ear infections______________
broken bone______________
vision problems______________
skin problems ______________
surgeries ______________
serious injuries ______________
high fevers (>103)______________
frequent stomach problems______________
kidney infections______________
bladder infections ______________

Additional information regarding above: ______________________________
____
____
____
Other (please specify) ______________________________
____
____

Who is your child's doctor? ______________________________
Does your child currently take any medication? ____ If yes, what? ______________
How long has your child been taking this medication? ______________
What is this medication for? ______________________________
Has your child previously been medicated long term for something? ____ If yes, for what?__________
What was this medication for? ______________________________
When was your child's most recent physical exam?______________
Does your child wear glasses? ___ a Hearing aid?_______ Have other special needs?__________
Has the child or family ever received counseling services? _____ If so, when, with whom, and why______________________________
____
____

Has the family been involved with other agencies outside of school (ie. Medicaid, Social Services, Public Health, fostercare)?________________________________

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DEVELOPMENTAL HISTORY

Birth Weight:_______ Length of Pregnancy:__________ Birthplace:_________________
Mother's Age at birth:___________________ Father's age at birth (if applicable):_______
Any complications during pregnancy? Yes / No. If yes, please describe:

____

____

Any complications during or at birth. Yes/ No. If yes, please describe: ______________

____

____

Please check the following that are true for you/your baby during pregnancy/birth:

Vitamins taken _____ prescription drugs taken_____ (please note what kind ________________)
Smoking___________ other drugs taken _____ (please note what kind____________________)
X-rays_____________ Alcohol consumption_____ (how much/how often__________________)
Normal birth _____ C-section______ Breech________
Other comments____

At approximately what age did your child do the following?

Walking ______ Speaking single words ______speaking in sentences ________ Potty training ___________

Please check if your child has experienced any of the following problems:
Unclear speech______ difficulty following directions ______ weight problem ________ sleep problem _____
Difficulty learning to ride a bike _____ difficulty learning to skip _____ difficulty learning to catch or throw _____
Temper tantrums _____ excessive crying_____ other ______________________________
Describe any of the above if helpful ___________________________________

SOCIAL/BEHAVIORAL

Please answer yes/no to the following and comment if you would like:

Question	Response	Comment
Has problems playing with other children	Yes / no	
Fights often with other children	Yes / no	
Prefers playing with younger/older children	Yes/ no	
Prefers to play alone	Yes / no	
Gets along with brothers/sisters	Yes / no	
Listens to parents	yes / no	
Kind to pets and animals	Yes/ no	
Has a short attention span	Yes / no	
Lacks self control	Yes / no	
Seems unhappy often	Yes / no	
Overly energetic in play	Yes / no	
Aggressive during play	Yes / no	
Threatens others	Yes / no	
Cries easily	Yes / no	
Easily frustrated	Yes / no	
Dresses self	Yes / no	

Uses good manners	Yes / no
Helps with household chores	Yes / no
Receives counseling outside of school	Yes / no
Receives counseling at school	Yes / no

EDUCATIONAL INFORMATION

Please answer the following questions:

Question	Response	Comment
Did your child attend preschool?	Yes / no	
Did your child receive special services as a preschooler? If yes, please explain below.	Yes/no	
Has your child changed schools frequently?	Yes / no	
Has your child been retained a grade in school?	Yes / no	
Does your child enjoy school?	Yes / no	
Is your child absent frequently?	Yes / no	
Does your child:		
Have difficulty with reading?	Yes / no	
Have difficulty with writing?	Yes / no	
Have difficulty with math?	Yes / no	
Get good grades (c or above)	Yes / no	
Has your child been tested individually? If yes, by whom?	Yes / no	

Preschool special services____

____

____

What do you see as your child's strengths? Weaknesses?

Do you feel that your child's educational program is satisfactory? If not, what changes do you think would be beneficial?

Any additional comments that would help us in working with your child?