

MEDICAL/DEVELOPMENTAL HEALTH HISTORY

Name of child: _____ Date of birth: _____ Age: _____

School presently attending: _____ Grade: _____

Presently lives with: _____ Relationship: _____

Mother's name: _____ Age: _____ Occupation: _____

Address: _____

Father's name: _____ Age: _____ Occupation: _____

Address: _____

Does this child live between two homes? Yes No

• If yes, where is child's primary residence? _____

• Who has legal custody? _____

• What are the arrangements? _____

• If divorce/separation, give date: _____

• Has there been a remarriage by either parent? Yes No

Address of primary household: (If child lives with both parents, use this as child's household) _____

Who lives in this household?

Name:	Age:	Gender:	Relationship:
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

If parents live together with child, go to next page.

Address of the other household: _____

Who lives in this household?

Name:	Age:	Gender:	Relationship:
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

DEVELOPMENTAL HISTORY

Please provide the following information regarding the development of your child:

Were there any complications during the pregnancy? Yes No

If yes, explain: _____

Were you under emotional stress during the pregnancy? Yes No

If yes, what were the events or environmental things that caused you to have stress?

Were any of the following things involved in your pregnancy? (Check any that apply and give details on the lines provided, i.e. amounts and frequency.)

- | Yes | No | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | prenatal vitamins _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | smoking _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | caffeine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | alcohol _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other drugs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | prescribed medications _____ |

Was there prenatal care? Yes No birth weight: _____

List any difficulties with birth: _____

Did the baby require an extended stay in the hospital? Yes No

If so, why? _____

Any other information regarding pregnancy not included above: _____

FAMILY HISTORY

Have any of your child's biological relatives suffered from any of the following conditions? Please check all that apply and specify mother, father, grandmother, grandfather, brother, sister, aunt, or uncle.

- | Yes | No | | Father's side | Mother's side |
|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | depression | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | hyperactivity/ADD | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | bed wetting | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Manic Depressive (Bi-Polar) Illness | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | attempted suicide | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | completed suicide | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | alcohol problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | drug problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | learning disability/Special Ed. | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | tic disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | thyroid disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | obsessive-compulsive behavior | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | other (please give details) | <input type="checkbox"/> | <input type="checkbox"/> |

EARLY CHILDHOOD PROBLEMS

Were there difficulties *during infancy* with any of the following: please check and explain

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	feeding _____
<input type="checkbox"/>	<input type="checkbox"/>	sleeping _____
<input type="checkbox"/>	<input type="checkbox"/>	excessive crying _____
<input type="checkbox"/>	<input type="checkbox"/>	extremely quiet _____
<input type="checkbox"/>	<input type="checkbox"/>	head banging _____
<input type="checkbox"/>	<input type="checkbox"/>	lack of eye contact _____
<input type="checkbox"/>	<input type="checkbox"/>	colic _____
<input type="checkbox"/>	<input type="checkbox"/>	excessive rocking by self _____
<input type="checkbox"/>	<input type="checkbox"/>	lack of smiling/cooing _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

- At what age did your child:

crawl _____	walk _____
talk in sentences _____	say their first word _____
complete toilet training: daytime _____	nighttime _____

- Were there problems that weren't within normal limits *before age 7*?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	nightmares	<input type="checkbox"/>	<input type="checkbox"/>	problems with other children
<input type="checkbox"/>	<input type="checkbox"/>	bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	inability to pay attention
<input type="checkbox"/>	<input type="checkbox"/>	messing pants	<input type="checkbox"/>	<input type="checkbox"/>	temper tantrums
<input type="checkbox"/>	<input type="checkbox"/>	impulse control	<input type="checkbox"/>	<input type="checkbox"/>	unusual fears
<input type="checkbox"/>	<input type="checkbox"/>	hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	aggression
<input type="checkbox"/>	<input type="checkbox"/>	night terrors	<input type="checkbox"/>	<input type="checkbox"/>	other (please list)
<input type="checkbox"/>	<input type="checkbox"/>	speech problems requiring speech therapy			

If you marked any of the above early childhood problems, please give details:

- Were OT/PT services required? Yes No
 If yes, when? _____ For how long? _____
 Where? _____

- To your knowledge, has your child ever been abused? Yes No

	Yes	No	By whom?	Relationship
If yes, physically	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
sexually	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
emotionally	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

- Did they receive professional help for it? Yes No
 Please explain the circumstances: _____

MEDICAL HISTORY

Has your child ever experienced any of the following? (Mark all that apply)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	major medical problem	<input type="checkbox"/>	<input type="checkbox"/>	hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	head injury	<input type="checkbox"/>	<input type="checkbox"/>	surgery
<input type="checkbox"/>	<input type="checkbox"/>	serious infection	<input type="checkbox"/>	<input type="checkbox"/>	allergy
<input type="checkbox"/>	<input type="checkbox"/>	prolonged and/or high fever	<input type="checkbox"/>	<input type="checkbox"/>	attempted suicide
<input type="checkbox"/>	<input type="checkbox"/>	seizures	<input type="checkbox"/>	<input type="checkbox"/>	broken bone
<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

If yes, please give details: _____

Has your child ever been limited from physical activity? Yes No

If yes, when? _____ for how long? _____

Does your child take any medication on a regular basis? Yes No

- If yes, name of medication: _____ dosage: _____
- reason for taking medication: _____
- list time(s) of day taken: _____
- Is it necessary to give it at school? Yes No
- What effects do you see from the medication? _____

If more than one medication is taken, please give names, dosages, times and reason for taking that medication and if it is effective: _____

List any other medical history not covered that you think is important for us to know in order that we may give your child the best opportunity for learning.

Name(s) of doctor(s) and how to contact them:

SCHOOL HISTORY

What previous school has your child attended?

School	Grade(s)
_____	_____
_____	_____
_____	_____
_____	_____

Has your child ever experienced any difficulties in school? Yes No

If yes, please mark any that apply and explain.)

Yes No

academic—what areas? _____

behavioral—please explain: _____

social—please explain: _____

Has your child ever been *diagnosed* with a learning disability? Yes No

If yes, when? _____ by whom? _____

• Specific disability: _____

• Were services received? Yes No

If yes, what services? _____ for how long? _____

From whom? _____

Has your child ever been in detention within school (in-house school detention)?

Yes No

• If yes, what school? _____

• When? _____ for how long? _____

• For what offense? _____

Has your child ever been expelled from any school? Yes No

• If yes, what school? _____

• When? _____ for how long? _____

• For what offense? _____

Has your child ever repeated a grade? Yes No Grade _____

• If yes, reason: _____

• Did it help? Yes No Explain: _____

Is there anything else we should know about your child's experiences in other schools to help us give your child the best education possible? _____

ENVIRONMENTAL STRESSORS

Have there been any major changes in your child's life? (Please give *dates* and *explain*)

- death of friend, family member, or pet _____

- moves _____

- illnesses _____

- ill health of family member _____

- financial problems _____

- other emotional stresses not mentioned above _____

Is this child, in or ever been in, the foster care system? Yes No

- If yes, who is the caseworker? _____
- How can we contact them? _____

Has this child, or any member of the immediate family, experienced any significant legal problems, present or past? Yes No

- If yes, who is involved? _____ relationship _____
- dates: _____
- the circumstances: _____

If your child has a Probation Officer, past or present, please give:

- P.O.'s name: _____
- How to contact them: _____

PSYCHOSOCIAL HISTORY

Please give as much detail as possible.

Have there been any significant relationship problems with other children?

Yes No

- If yes, which children? _____ relationship _____
- How long has this been going on? _____
- Do you have any idea why these problems might be occurring? _____

Have there been any significant relationship problems with adults? Yes No

- If yes, which adults? _____ relationship _____
- How long has this been going on? _____
- Do you have any idea why these problems might be occurring? _____

Please list your child's strengths: (i.e. good with children, good at coloring, athletics, etc.)

Please list what your child does for fun: _____

Is your child currently receiving, or ever received, counseling? Yes No

- If yes, when? _____
- With whom? _____
- Where? _____
- For how long? _____
- For what reason? _____

Is there anything not covered in this history you think is important for us to know so we can give your child the best opportunity for learning? _____

Is this child covered by private insurance? Yes No

- If applicable, Medicaid number: _____

Parent's signature: _____ Date: _____

To be completed by the school health office

Immunization status: Up to date In process Needs booster Exemption

Height: _____, _____% **Weight:** _____, _____%

Dental exam: Clean Gingiva pink Caries Fillings

Vision: Right 20/____ Left 20/____
Corrected Right 20/____ Corrected Left 20/____

Nutrition assessment: Appears well nourished Yes No
Breakfast: at home at school
Lunch: from home at school
Snacks: _____
Comments: _____

Hygiene:	Clothing clean	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nails trimmed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Skin clean	<input type="checkbox"/>	<input type="checkbox"/>	Hair combed	<input type="checkbox"/>	<input type="checkbox"/>
	Hair clean	<input type="checkbox"/>	<input type="checkbox"/>	Clothing appropriate (to weather, age and place)	<input type="checkbox"/>	<input type="checkbox"/>

Interaction:	Makes eye contact	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Socially responsive and appropriate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Speech clear	<input type="checkbox"/>	<input type="checkbox"/>		Other _____	

Student's interests: _____

Before school care: _____

After school care and activities: _____

Attendance history: _____

School services currently receiving: _____

Nurse's comments on noteworthy medical/behavioral data (school problems, family disruptions, etc.)

School Nurse's Signature

Date