MEDICAL/DEVELOPMENTAL/SOCIAL HISTORY

ECSE Program/West Ada School District

Child's Name: _____ Birth date: _____ Age: _____

Address: _____ City: _____ State: ID Zip code: _____

Home Phone: _____ E-Mail: _____

FAMILY

Father's Name: _____Check One: ☐natural ☐step ☐foster ☐adopted ☐grandparent

Father's Employment: _____ Cell/Work Phone: _____

Mother's Name: _____Check One: ☐natural ☐step ☐foster ☐adopted ☐grandparent

Mother's Employment: _____ Cell/Work Phone: _____

Does your child have Medicaid coverage? Yes ___ No ____ Medicaid Number _____

Primary Language Spoken in Home: _____ Other Languages in Home: _____

People Living in the Home (including parents):

Name	Age	Sex	Relationship to Child

Childcare/Preschool History:

Childcare/Preschool (Name, Address & Phone)	Age Child Attended and Length of Time Attended

Therapy History

Therapy/Therapist (Name, Address & Phone)	Age Child Attended and Length of Time Attended

PREGNANCY INFORMATION

Did the mother have on-going prenatal care? Yes ____ No ____

Number of previous pregnancies _____ miscarriages _____

Check any of the following complications that occurred during the pregnancy:

❑ Excessive swelling ❑ Excessive vomiting ❑ Abnormal weight gain
❑ Abnormal weight loss ❑ High blood pressure ❑ Flu
❑ Emotional problems ❑ Vaginal bleeding ❑ Toxemia
❑ Anemia
❑ X-ray (not ultrasound) during pregnancy: What month(s)? _____ Reason: _____
❑ Other (Rh incompatibility, measles, other illnesses, etc.) Describe: _____
❑ Maternal injury: Describe: _____
❑ Hospitalization during pregnancy: Reason/length of time: _____
❑ Medications used during pregnancy: What kind? _____
❑ Alcohol used during pregnancy: Frequency? _____
❑ Cigarettes used during pregnancy: Frequency? _____
❑ Other drugs used during pregnancy:

Type	Frequency	Prescription
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

BIRTH:

At this child's birth, what was the mother's age? _____ Father's age? _____

Was this child born in a hospital? Yes _____ No _____ if no, where? _____

Length of pregnancy: _____ weeks (40 is full term) Birth weight: _____ lbs. _____ oz.

Any problems during labor (long labor, medications, etc.)? Explain: _____

Child's condition at birth: _____

Mother's condition at birth: _____

BIRTH (continued):

Check any of the following complications that occurred during birth:

❑ Forceps used ❑ Suction used ❑ Breech birth ❑ Labor induced
❑ Emergency C-section ❑ Planned C-section ❑ NICU-Length of Time: _____
❑ Other delivery complications: Describe: _____

❑ Incubator: How long? _____ ❑ Jaundiced: Bilirubin lights? Yes ☐ No ☐ if yes how long? _____

❑ Breathing problems right after birth: Describe: _____

Length of stay in hospital for baby after delivery: _____

DEVELOPMENT

Indicate at what age this child first did the following (indicate year and month):

_____ Sat alone _____ Spoke first words _____ Toilet trained during day
_____ Walk alone _____ Put 2-3 words together _____ Toilet trained during night

On average, how many words per sentence does your child say? ___ 2-3 words ☐ 4-6 words ___ 7+ words

MEDICAL HISTORY

Has your child ever had…	Yes	No	Age	Describe
High fevers (103 or higher)				
Allergies (food or other)				
Seizures/convulsions				
Injuries to head				(Unconscious?)
Unconsciousness/fainting spells				
Any major injuries				
Hospitalizations				
Operations				
Frequent ear infections				(Frequency, tubes?)
Pneumonia				
Chicken Pox				
Meningitis				
Measles, Mumps, or Whooping Cough				
Tuberculosis				
Other Contagious Illness				
Problems hearing				(Temporary or permanent?)
Problems seeing				(Glasses?)
Problems passing urine				
Problems passing stool				
Dental problems				
Tonsils/Adnoids				

MEDICAL HISTORY (continued):

Are there any other health problems that the school personnel need to be aware of in working with your child? (i.e. health problems, diabetes, epilepsy, short attention span, hyperactivity, cerebral palsy, spinal bifida, genetic disorders, cleft palate, food allergies, special diet, etc.)?

_____
_____
_____
_____

Name of Primary Care Physician: _____
Name of Specialist Physician, Dentist, etc.: _____
Number of times you child has had to have medical care in the past year: _____

Child's Medication History

Prescription drugs taken for 14 days or longer:

Name of drug: _____ For what condition: _____

Over the counter drugs taken for any ongoing medical condition:

Name of drug: _____ For what condition: _____

GENERAL INFORMATION:

What are your child's basic strengths?

_____
_____
_____
_____

What are your child's favorite games to play or toys to play with?

_____
_____
_____
_____

How does your child do with books? Do they enjoy story time?

_____
_____
_____

What are some of the social opportunities your child has been given?

❑ preschool ❑ church/Sunday school ❑ siblings
❑ play groups ❑ library ❑ parks/playgrounds/pools
❑ other: _____

AREAS OF CONCERN:

The following is a list of potential concerns you might have regarding your child. Please indicate in which of the broad areas you have a concern, then mark the specific concerns you have as well as any interventions that have been implemented.

A. _____ Social/Emotional/Behavioral Concerns

❑ aggressive ❑ easily angered ❑ does not separate easily from parent(s)
❑ lies ❑ temper outbursts ❑ Resists rules or refuses to comply with request to accept limits
❑ lethargic ❑ excitable ❑ disturbs other children
❑ destructive ❑ withdrawn ❑ disruptive to family
❑ shy ❑ jealous ❑ does not play well with other children
❑ nervous habits ❑ steals ❑ will not work or play in a group
❑ sullen/sulky ❑ quarrelsome ❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ rewards ❑ time-out/remove from situation ❑ counseling ❑ role model/teach appropriate behavior
❑ other _____

B. _____ Self-Help Concerns

❑ feeding problems ❑ dressing problems ❑ toileting problems
❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ use of regular cups/utensils/straws ❑ allow time and opportunity to dress self
❑ use of regular underwear ❑ use of toileting schedule
❑ other: _____

C. _____ Speech/Language Concerns

❑ speech is unclear or garbled ❑ difficulty expressing wants
❑ incomplete sentence structure ❑ often needs instruction repeated
❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ modeling correct speech/sentence structure ❑ private speech/language services
❑ other: _____

D. _____ Fine Motor Concerns

❑ tremors ❑ difficulty using tools (pencils, scissors, etc)
❑ poor hand/eye coordination ❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ use of pencil grip ❑ use of larger writing utensils (pencil, crayons)
❑ private occupational therapy ❑other: _____

E. _____ Gross Motor Concerns

❑ clumsy ❑ poor control of body movements
❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ opportunities for use of playground/large equipment (slides, climbing, balls)
❑ private physical therapy ❑ other: _____

F. _____ Developmental Concerns

❑ delays in developmental milestones such as talking, walking, etc
❑ does not appear to learn at an average rate ❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ reading at home/library activities ❑ expanding vocabulary (pointing things out while driving/walking)
❑ counting activities (counting cereal, counting forks while setting table) ❑ sing ABC song
❑ practicing number and letter recognition ❑ other: _____

G. _____ Unusual Behaviors

❑ excessive crying ❑ extremely quiet ❑ lack of interest in other people ❑ head banging
❑ lack of eye contact ❑ rocking ❑ lack of appropriate play with toys
❑ Other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ medical intervention (pediatrician's advice, medication)
❑ other: _____

H. _____ Attention Concerns

❑ day dreams ❑ impulsive ❑ hyperactive ❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ medical intervention (pediatrician's advice, medication) ❑ use of timer ❑ time out
❑ behavior charts, rewards ❑other: _____

I. _____ Sleeping and/or eating

❑ difficulty falling asleep ❑ sleeps less than most children ❑ sleeps more than most children
❑ overeats ❑ eats very little ❑ picky eater
❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ medical intervention (pediatrician's advice, medication) ❑ providing a variety of foods at meals
❑ other: _____

J. _____ Child Abuse

❑ physical ❑ sexual ❑ neglect ❑ other: _____

***What other interventions have been tried at home or daycare/preschool**

❑ counseling/medical attention ❑ Health and Welfare involvement
❑ other: _____

Circumstances in this child's life that you think would help us to understand your child (divorce, separation, foster placement, moves, other). Please explain.

_____
_____
_____
_____
_____

<u>This information may be shared with school personnel on a need to know basis.</u>

Parent/Guardian Signature: _____ Date: _____