Development, Health & Social History
Preschool & Kindergarten Only

Student Name____
(first) *(middle)* *(last)*

PRESCHOOL HISTORY
Did child attend preschool? ☐ Yes ☐ No
If yes, preschool attended______________________________ Dates attended____________________

INTERVENTION EVALUATION
Has child been evaluated for intervention services? ☐ Yes ☐ No
If yes, where____ and when__________________________
Type of intervention received____

SERVICES RECEIVED IN THE PAST/PRESENT
☐ Psychological Evaluation ☐ Individualized Education Program (IEP)
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
Name of Children's Services Agency____
Name of Counseling Agency____
Name of Private Physician____

MEDICAL INFORMATION
A. Prenatal
Health of mother during pregnancy ☐ Excellent ☐ Fair ☐ Poor
Were there any unusual event/complications during pregnancy? ☐ Yes ☐ No
If yes (drugs, bleeding, measles, spotting, toxemia, medication, etc.) please specify:
____
____
____

B. Childbirth
Was your child premature? ☐ Yes ☐ No If yes, how many weeks premature?_______________
Were there complications during birth? ☐ Yes ☐ No If yes, please check issue(s) below:
☐ Cesarean ☐ Breech ☐ RH ☐ Toxemia ☐ Need for Oxygen
Baby's Birth Weight ___________ Birth Defects____

C. Early Childhood
Has your child ever had:
Surgeries ☐ Yes ☐ No If yes, age and reason____________________________________
High Fevers ☐ Yes ☐ No If yes, age and temperature_______________________________
Ear Infections ☐ Yes ☐ No If yes, age or ages_______________________________________

Serious Injuries ☐ Yes ☐ No If yes, age or ages_______________________________________

D. Current Health Status

Date of most recent Physical Examination _____/_____/_____

Does your child have allergies? ☐ Yes ☐ No

If yes, list allergies:____

Are allergy life-threatening? ☐ Yes ☐ No

Does your child require daily medication? ☐ Yes ☐ No

If yes, list medications:____

Date of most recent Hearing Examination _____/_____/_____

Does your child require any hearing devices? ☐ Yes ☐ No

If yes, explain:____

Date of most recent Vision Examination _____/_____/_____

Does your child wear glasses? ☐ Yes ☐ No

If yes, explain:____

CURRENT BEHAVIORAL INFORMATION

Does your child like to play with ☐ a large group ☐ 1-2 other children ☐ alone

Do they have temper tantrums? ☐ Yes ☐ No If yes, how long do they last?_______________

Do they sleep well? ☐ Yes ☐ No What time is bedtime?________________________________

Do they wet? ☐ Yes ☐ No Do they soil? ☐ Yes ☐ No

What is their preferred hand? ☐ Left ☐ Right ☐ Neither

Comments____

Do they follow instructions or orders at home? ☐ Yes ☐ No

Comments____

Do they respect their own/other's property? ☐ Yes ☐ No

Comments____

Do they respond to correction? ☐ Yes ☐ No

Comments____

Most effective type(s) of discipline____

____

____

Check the characteristics that apply to your child most of the time:

☐ Happy	☐ Friendly	☐ Shy	☐ Moody	☐ Stubborn
☐ Aggressive	☐ Impulsive	☐ Bored	☐ Inattentive	☐ Immature

Please list any other developmental, health, or social issues not listed above:

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