ADAIR COUNTY SCHOOLS

Learning For A Lifetime

EARLY CHILDHOOD DEVELOPMENTAL HISTORY

Student's Name: _____ Date of Birth: _____ Date: _____

Name of Person Filling Out Form: _____ Relationship to Student: _____

Home Address: _____ Zip: _____ Home Phone: _____

Father's Name: _____ Mother's Name: _____

Student lives with (Check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent

☐ Grandparent ☐ Other (Specify): _____

Best Number(s) to reach parent/guardian:

Name: _____ ☐Work: _____ ☐Cell: _____ ☐Other(Specify): _____

Name: _____ ☐Work: _____ ☐Cell: _____ ☐Other(Specify): _____

If the child does not live with both biological parents, how often does the child see the parent with whom he/she does not live: _____

Other people living in the home:

Name	Age	Male/Female	Relationship to student

Has your child ever attended: ☐ preschool ☐ daycare ☐ Headstart ☐ Not Applicable

If so, where: _____ Date attended: _____

Early Development

Was the child born full-term? ☐Yes ☐No If not, how many weeks was the pregnancy? _____

Was the child adopted? ☐Yes ☐No If yes, how old was child when adopted? _____

Did the mother experience any of the following during this pregnancy?

☐ Serious illness/injury(specify): _____ ☐ Alcohol or drug use/abuse

☐ Other: _____

Did your child experience any of the following difficulties during delivery?

☐Emergency cesarean section delivery ☐Low birth weight ☐Delivered with cord around neck

☐Cardiopulmonary distress ☐Cyanosis (turned blue) ☐Needed oxygen ☐Seizures

☐Birth defect(specify):_____

☐Injury(specify):_____ ☐Other:_____

How was your child's temperament as a baby (happy, cuddly, fussy, colicky)?_____

Please check the box that best describes when your child reached developmental milestones*:

Sitting: ☐Early(3-6 months) ☐Average(7-12 months) ☐Late(over 1 year) ☐Don't Know

Walking: ☐Early(7-12 months) ☐Average(12-18 months) ☐Late(over 18 months) ☐Don't Know

Speaking 2 to 3 word sentences: ☐Early(9-17 months) ☐Average(18-24 months) ☐Late(over 24 months) ☐Don't Know

Toileting: ☐Early(1-2 Years) ☐Average(2-3 Years) ☐Late(over 3 years) ☐Not potty trained ☐Don't Know

*Age range information from Centers for Disease Control and Prevention [CDC]

Has your child received any early intervention services (e.g. First Steps)? ☐ Yes ☐ No

If so, what county and/or state?_____

Which of the following services did your child receive through early intervention?

☐speech therapy ☐occupational therapy ☐physical therapy ☐developmental intervention (DI)

Health and Wellness

Does the family have a history of any of the following(check all that apply)?

☐Alcohol or drug use/abuse ☐Anxiety disorder ☐Depression ☐Bipolar disorder

☐Autism ☐Learning/Reading problems ☐Behavioral difficulties ☐ADHD ☐ ADD

The child's overall health is: ☐Good ☐Fair ☐Poor

What is your child's bedtime?_____ Does your child currently have problems sleeping? ☐Yes ☐No

If yes, please specify(check all that apply): ☐Difficulty falling asleep ☐Wakes too early ☐Nightmares

☐Loud snoring ☐Awakens during night ☐Restless sleeper ☐Sleep apnea ☐Bedwetting

Does your child have eating difficulties? ☐Yes ☐No

If yes, please specify: ☐Chews with tongue instead of teeth ☐Gags easily ☐Continuous drooling

☐Strangles easily ☐Does not eat certain foods because of texture ☐Swallowing difficulties

☐Other_____

Does your child have a pediatrician/primary caregiver? ☐Yes ☐No

Doctor's Name:_____Last checkup date:_____Any significant findings? ☐Yes ☐No

(If yes, please explain)_____

Does your child take medication on a regular basis? ☐Yes ☐No If so, please list below:

Medication	Dosage	Reason

At any time has your child had the following? (Mark "C" if current problem, "P" if previous but not ongoing)

_____Asthma
_____Epilepsy or seizure disorder
_____Head injury with loss of consciousness
_____High fevers (over 103°F)
_____Febrile seizures (due to fever)
_____Chronic ear infections/tubes in ears
_____Allergies(specify):_____
_____Diabetes Other:_____

Vision problems? ☐Yes ☐No Please describe:_____

Have glasses or contacts been prescribed? ☐Yes ☐No Does your child wear them? ☐Yes ☐No

Hearing problems? ☐Yes ☐No Please describe:_____

Does your child wear a hearing aid? ☐Yes ☐No

Does your child have any other medical diagnoses (physical or mental)? ☐Yes ☐No
If yes, please explain_____

Has your child been hospitalized for medical treatment? ☐Yes ☐No
When?_____Why?_____Hospital:_____
When?_____Why?_____Hospital:_____

Has your child or immediate family member been hospitalized for psychiatric treatment? ☐Yes ☐No
When?_____Why?_____Hospital:_____
When?_____Why?_____Hospital:_____

Has your child had a psychological evaluation outside of school? ☐Yes ☐No
Date:_____Agency:_____

Has your child received counseling (e.g Adanta, Life Skills)? ☐Yes ☐No
When?_____Why?_____Agency:_____
When?_____Why?_____Agency:_____
These hospitals and agencies will not be contacted unless you have signed an Authorization to Disclose Information form.

Home and Community

What is the primary language spoken by parents?_____by child?_____

How does your child spend time while at home? Please use following letters to indicate frequency:
A = Almost Always, O = Often, S = Sometimes, N = Never

_____Reading/being read to
_____Spending time with family members/friends
_____Watching TV
_____Playing outside
_____Playing with toys
_____Playing video games
_____Using the computer
Other_____

How are your child's relationships with the following? (Please specify good/fair/poor)

Parents_____ Other adults_____ Siblings_____ Peers_____

What forms of discipline and behavior management are used with your child?
Please use the following to indicate frequency (often/sometimes/rarely).

_____Time-out
_____Behavior chart/Rewards system
_____Spanking
_____Loss of certain toys for a specific time
_____Loss of privileges
Other_____

How does your child usually react to discipline? ☐complies ☐complains ☐does not care/indifferent

☐temper tantrums/fits/meltdowns other:_____

Has your child experienced any of the following stressful events within the past 12 months?
(Please check all that apply)

☐Parents divorced/separated ☐Family moved ☐Family financial problems ☐Homelessness

☐Custody change ☐Family accident/illness ☐Death in family ☐Addition of a new family member

Other_____

Is there a history or suspicion of physical abuse? ☐Yes ☐No Sexual abuse? ☐Yes ☐No

Emotional abuse? ☐Yes ☐No Neglect? ☐Yes ☐No

Has your child ever made comments about wanting to harm him/herself or others? ☐Yes ☐No

If yes, please explain:_____

Has your child ever been involved in the foster care system or the court system? ☐Yes ☐No

If yes, please explain:_____

Please check any and all of the following that describes your child:

☐Caring	☐Clumsy	☐Confident	☐Responsible
☐Rude/back-talks	☐Funny	☐Excessive energy	☐Independent
☐Angry/hot tempered	☐Shy	☐Daydreams	☐Friendly
☐Acts immature for age	☐Nervous nature	☐Frequently cries	☐Low energy
☐Often argues	☐Poor manners	☐Oversensitive	☐Talented
☐Physically aggressive	☐Kind	☐Generally happy	☐Competitive
☐Lies	☐Lazy	☐Generally unhappy	☐Lonely
☐Steals	☐Clowns around	☐Lacks self-confidence	☐Withdrawn
☐Destructive	☐Creative	☐Perfectionist	☐Low self-esteem
☐Moody	☐Imaginative	☐Self-destructive	☐Intelligent
☐Excessive interest in sexual matters	☐Helpful	☐Athletic	☐Bully's others

In which of these areas would you like to see your child improve most? _____

_____

Please list any other concerns, family history, developmental history, etc. that you think we should be aware of and was not listed on this form:

_____

_____

_____

****Any information given is confidential—Your child's records are protected****