**SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE**

**I. GENERAL INFORMATION**

Child’s full name: Click here to enter text. DOB: Click here to enter a date.

Age: Click here to enter text. Grade: Choose an item.

Classroom teacher: Click here to enter text.

Interviewer: Click here to enter text. Date of Interview: Click here to enter a date.

Current Address: Click here to enter text.

How long at this address? Click here to enter text.

Person providing information: Click here to enter text.

Relationship to child: Click here to enter text.

Who does child live with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (specify) Click here to enter text.

Biological father: Click here to enter text. Occupation: Click here to enter text. Number of Years education: Choose an item.

Father’s home phone: Click here to enter text. Work #: Click here to enter text. Cell #: Click here to enter text.

Biological mother: Click here to enter text. Occupation: Click here to enter text. Number Years education: Choose an item.

Mother’s home phone: Click here to enter text.Work #: Click here to enter text. Cell #: Click here to enter text.

If applicable: Guardian’s name: Click here to enter text. Occupation: Click here to enter text. Number of Years education: Choose an item.

Guardian’s home phone: Click here to enter text. Work #: Click here to enter text.Cell #: Click here to enter text.

Please list all people in child’s immediate family: Click here to enter text.

Name Relationship to child Age/Grade Living in house? Click here to enter text.

Please list all other *non-family* members who live in household: Click here to enter text.

Name/relationship to child/family: Click here to enter text.

How long has lived in household? Click here to enter text.

Language(s) spoken at home: Click here to enter text.

Primary Language at home: Click here to enter text.

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace Click here to enter text. Moved at ageClick here to enter text. Grade Choose an item.

2. Click here to enter text. Moved at ageClick here to enter text. Grade: Choose an item.

3. Click here to enter text. Moved at ageClick here to enter text. Grade: Choose an item.

4. Click here to enter text. Moved at ageClick here to enter text. Grade: Choose an item.

Are biological parents of child currently: ☐ Married ☐ Separated ☐Divorced ☐ Never Married

If separated or divorced, who has *legal* custody? ☐ Mother ☐ Father ☐ Other (specify): Click here to enter text.

If separated or divorced, how do you feel your child has adjusted to the separation/divorce?Click here to enter text.

Are there other adults who have a ***significant*** part in raising your child? ☐Yes ☐No

If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.): Click here to enter text.

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc.): Click here to enter text.

What do you feel are your child’s:

Strengths: Click here to enter text.

Weaknesses: Click here to enter text.

Briefly describe your concerns for your child: Choose an item.

**II. HEALTH AND DEVELOPMENT**

**A. Pregnancy and Birth**

Is your child: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other: Click here to enter text.

Mother’s age at birth? Click here to enter text.

Did mother receive routine medical prenatal care? ☐Yes ☐ No

Please specify any medications used during pregnancy and the reason used: Click here to enter text.

Pregnancy lasted Click here to enter text. Weeks/Months

Child’s birth weight: Choose an item. Pounds Choose an item. Ounces

APGAR score …at 1 minute Click here to enter text. …at 5 minutes Click here to enter text.

☐ Unsure / Don’t know

Did child go home from the hospital at the same time as the mother? ☐Yes ☐ No

If No, explain why: Click here to enter text.

**Please check the conditions below that describe the health of the child and mother during…**

|  |  |
| --- | --- |
| Mothers pregnancy | Child’s Delivery |
| ☐No complications | ☐Normal |
| ☐Blackouts | ☐Induced labor |
| ☐Falls | ☐C-section |
| ☐Physical injury | ☐Breech birth |
| ☐Excessive bleeding | ☐Unusually long labor (>12 hours) |
| ☐Hypertension | ☐Premature # of weeks |
| ☐Diabetes | ☐Overdue # of weeks |
| ☐Emotional stress | ☐Other problem (specify) Click here to enter text. |
| ☐Toxemia |
| ☐Alcohol and/or drug use |
| ☐Use of tobacco |

|  |
| --- |
| Child’s Condition at Birth |
| ☐Normal |
| ☐Lack of oxygen |
| ☐Breathing problem |
| ☐Birth injury/defect |
| ☐Jaundice |
| ☐Newborn ICU # of days Click here to enter text. |
| ☐Other problem (specify) Click here to enter text. |

**B. Health**

Describe the state of your child’s current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medication? ☐Yes ☐ No

If yes, please list medications and uses: Click here to enter text.

Has your child ever been identified as having a disability? ☐Yes ☐No

If so, by whom, what age, & what disability? Click here to enter text.

Has your child ever received psychological counseling? ☐Yes ☐ No

If so, by whom (professional/agency) and when: Click here to enter text.

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc.)? ☐Yes ☐ No

If so, by whom (professional/agency) and when: Click here to enter text.

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? ☐Yes ☐ No

If so, by whom (professional/agency) and when: Click here to enter text.

Has your child ever participated in an early intervention program? ☐Yes ☐ No

If so, by whom (professional/agency) and when: Click here to enter text.

|  |  |
| --- | --- |
| Has your child had any of the following? Please check all that apply.  | Please describe and give details, dates, and/or age of onset |
| ☐Serious Illnesses |  |
| ☐Head Injuries |  |
| ☐Seizures or convulsions |  |
| ☐Surgery/Hospitalization |  |
| ☐History of Ear Infections |  |
| ☐Allergies and/or Asthma |  |
| ☐Vision Problems |  |
| ☐Hearing Problems |  |
| ☐Frequent Nightmares and/or Bedwetting |  |
| ☐Other health problem |  |

**Family History**

|  |  |
| --- | --- |
| Is there a ***family history***for the following problems? | *Biological* family member with the history…(Parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc.) |
| ☐Learning Difficulties (reading, math, writing, spelling) |  |
| ☐Speech or Language problem (articulation, stuttering, etc.) |  |
| ☐Developmental Disorder (such as Autism, Asperger’s disorder, etc.) |  |
| ☐Emotional Problems (depression, excessive anxiety, mood swings, etc.) |  |
| ☐Intellectual Disability |  |
| ☐School Failure (failing grades, dropout, etc.) |  |
| ☐Drug or Alcohol Addiction |  |

**C. Development**

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Milestone** | 0-3 months | 4-6 months | 7-12 months | 13-18 months | 19-24 months | 2-3 years | 3-4 years | Not Yet Achieved | Other (specify age) |
| Sat up without help | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Crawled | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Walked alone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Walked upStairs | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Spoke first words | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ |  |
| Spoke short phrases | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Spoke in sentences | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Fully bladder trained | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Fully bowel trained | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |
| Stayed dry all night  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |  |

**III. BEHAVIOR**

**A. Behavior in Infancy**

During your child’s first *few years of life*, were any of the following present to *significant* degree?

|  |  |
| --- | --- |
| ☐Did not enjoy cuddling | ☐Difficult nursing  |
| ☐Was not easily calmed by being held or being stroked  | ☐Poor eye contact |
| ☐Difficult to comfort | ☐Did not turn towards caregivers |
| ☐Colicky  | ☐Did not respond to name  |
| ☐Excessive irritability | ☐Did not respond to speech of caregivers  |
| ☐Diminished sleep | ☐Fascination with certain objects |
| ☐Frequent head banging  | ☐Constantly into everything |

\* Please describe all checked itemsClick here to enter text.

**B. Child’s Early Temperament: (*Toddler through five years of age*)**

☐ Activity Level – How active has your child been from an early age?Click here to enter text.

☐ Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks? Click here to enter text.

☐ Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? Click here to enter text.

☐ Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? Click here to enter text.

☐ Intensity – Whether happy/unhappy, how strong were your child’s feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? Click here to enter text.

☐ Mood **–** What was your child’s basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? Click here to enter text.

☐ Regularity **–** How predictable was your child’s patterns of activity level, sleep, appetite, etc.? Click here to enter text.

Prior to age six, did your child have more difficulty than other children his/her age:

|  |  |
| --- | --- |
| ☐Sitting still at meal time | ☐Staying focused on TV, movies, or video games |
| ☐Paying attention when read to | ☐Waiting for a turn to play |
| ☐Throwing a ball | ☐Knowing left and right |
| ☐Catching a ball | ☐Acting without thinking |
| ☐Buttoning and zipping | ☐Dressing self |
| ☐Holding a crayon or pencil | ☐Tying shoe laces |
| ☐Accidentally dropping things | ☐Accidentally knocking things over |

**C. Differential Behaviors**

Please check below all behaviors or characteristics that fit your child over the past year:

|  |  |
| --- | --- |
| ☐Fidgets, easily distracted, difficulty staying seated | ☐Often depressed/irritable mood  |
| ☐Talks excessively, interrupts often, doesn’t listen | ☐Often loses things, very disorganized  |
| ☐Low energy/fatigue | ☐Shy |
| ☐Poor concentration | ☐Feeling of worthlessness or low self-esteem |
| ☐Difficulty initiating tasks | ☐Withdrawn |
| ☐Difficulty completing tasks | ☐Overly anxious or fearful |
| ☐Difficulty following instructions | ☐Sleeping too little/insomnia |
| ☐Engages in impulsive behaviors (acts before thinking) | ☐Sleeping to much |
| ☐Immature compared to peers | ☐Difficulty making decisions |
| ☐Engages in physically dangerous activities | ☐Cries easily |
| ☐Often argumentative with adults | ☐Temper tantrums |
| ☐Often actively defiant to adult requests and rules | ☐Rapid mood changes/mood swings |
| ☐Blames others for own mistakes | ☐Suicidal thoughts |
| ☐Often angry or resentful | ☐Excessive need for reassurance |
| ☐Somatic complaints of not feeling well | ☐Poor appetite  |
| ☐Excessive separation difficulties | ☐Overeats |
| ☐Easily frustrated  | ☐Explosive temper with minimal provocation |
| ☐Lies | ☐Odd fascinations |
| ☐Steals | ☐Unrealistic worry about futures events  |
| ☐Aggressive towards others☐Adults ☐Peers  | ☐Substance abuse ☐Drug☐Alcohol☐Other Click here to enter text. |

Please explain all checked items: Click here to enter text.

**D. Home Behavior:**

How often is each of the following settings a *problem* for your child?

|  |  |  |  |
| --- | --- | --- | --- |
| While getting ready for school | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When eating at the dinner table | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When playing by him/herself | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When playing with siblings/other children | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When with a babysitter or daycare | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| In public places (church, store) | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When in the car | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When told to do something he/she doesn’t want to do | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| During sit-down homework time | ☐Rarely  | ☐Sometimes | ☐Frequently  |
| When watching TV or playing video games | ☐Rarely  | ☐Sometimes  | ☐Frequently  |

How would you describe your child’s personality at home?Click here to enter text.

How does your child get along with brothers/sisters? Click here to enter text.

Which adult would your child prefer to talk with about a problem? Click here to enter text.

Who is the *family member* with whom your child feels closest? Click here to enter text.

Who is primarily responsible for discipline at home? Click here to enter text.

What is the most effective way to deal with your child’s behavior problems at home? (Spanking, talking, positive reinforcement, time-out, grounding, etc.)Click here to enter text.

How does your child respond to discipline?Click here to enter text.

List any responsibilities your child has at home: Click here to enter text.

Does your child do these regularly? ☐ Yes ☐ No

Does your child need frequent reminders? ☐Yes ☐No

Indicate child’s… Bed time? Click here to enter text.PM Wake time?Click here to enter text. AM

Does child sleep well? ☐Yes ☐No

How much time does your child typically spend on electronic media? Choose an item.

Watching TV: Choose an item. Hours/day; Playing video/computer games: Choose an item. Hours/day; Other: Click here to enter text. Hours/day Choose an item.

Have any family members expressed concerns about your child’s behavior? ☐Yes ☐ No

Explain: Click here to enter text.

**E. Social Behavior:**

How would you describe your child’s peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc.? Does child associate w/ scholars or troublemakers?) Click here to enter text.

How does your child interact with children in the neighborhood?Click here to enter text.

 **IV. Educational History**

How does your child feel about school? Click here to enter text.

How motivated do you feel your child is to learn? Click here to enter text.

About how much time does your child spend on homework each night? Click here to enter text.

How much of a struggle is homework? ☐ Not a struggle ☐ Sometimes a struggle ☐ Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? ☐ Yes☐ No

If yes, what services, when did they begin?Click here to enter text.

Below, please list schools attended and describe your child’s academic and/or behavioral performance:

Preschool/DaycareClick here to enter text.

Elementary SchoolClick here to enter text.

Middle SchoolClick here to enter text.

High School Click here to enter text.

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Interviewer’s Signature