JESSAMINE COUNTY SCHOOLS
PRESCHOOL / KINDERGARTEN SOCIAL & DEVELOPMENTAL HISTORY

I. CHILD INFORMATION

Child's Name: ___________________________ Race: ______ Sex:______ Birthdate:___________ Age:____

Childs' Social Security # (optional)________________________________ Phone:________________________

Parents: ____

Address: ____

II. FAMILY INFORMATION

List all persons living in Child's Home (including step-parents and siblings):

Name	DOB	Age	Relationship to Student	School Attending	Last Grade Completed

List brother and/or sisters living outside the home:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Does the family have a history of any of following? (check if applicable)

❑ Excessive alcohol use ❑ Drug use ❑ Learning Problems/Dyslexia ❑ Depression ❑ Anxiety

❑ Autism ❑ Bipolar Disorder ❑ Attention Deficit Hyperactivity Disorder

Has your child experienced any of the following stressful events? (check if applicable)

❑ Parents divorced/separated ❑ Parent changed or lost job ❑ Custody change ❑ Family moved

❑ Death in family ________________ ❑ Homelessness ❑ Family financial problems

❑ Family illness/accident ❑ Relative in jail ❑ Abuse ❑ Neglect

❑ Child involved with Department of Community Based Services (DCBS)

Is anyone in the family currently enrolled in any college courses? ❑ yes ❑ no

Is anyone in the family currently enrolled in an adult education/GED/Literacy program? ❑ yes ❑ no

Does anyone in the family need adult education/literacy or GED preparation services? ❑ yes ❑ no

Please circle any services your child presently receives: food stamps home health social services first steps day care assistance counseling services other:____

Does the family need assistance to locate/secure any social services (eg. food stamps, housing, child care, medical, dental, etc.) ❑ yes ❑ no If yes, please explain:

____

____

Who cares for your child during the work day? ____________________

Does the child have a medical card? ❑ yes ❑ no If yes, give number ____________________

Who has legal custody of this child? ____________________

If divorced, please circle type of custody awarded: Joint Custody Sole Custody

III. BIRTH/MEDICAL HISTORY

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

❑ Serious illness or injury (Specify): ____________________ ❑ Alcohol use ❑ Drug use

❑ Other: ____________________ ❑ Smoking ❑ Prenatal Care

How many weeks or months was the pregnancy? ____________________

Baby's birth weight was: __________ Please circle type of birth: Normal Caesarean Breech Twins

Birth was: ❑ Normal ❑ Caesarean ❑ Breech ❑ Twins

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: ____________________

Did your child stay in the NICU (neonatal intensive care unit)? ____________________

If so, how long?____________________

Has your child been evaluated previously? ❑ Yes ❑ No

If yes,

- When was the child evaluated? ____________________
- What was the area(s) of concern?____________________

Is your child's health poor, good, or excellent? ____________________

List any current medical problems your child has: ____________________

List any medications your child is currently taking: ____________________

Is your child involved in counseling services? ❑ Yes ❑ No

If yes, list name of agency ____________________

Do you need follow-up services for any of the above mentioned issues? Yes No

Have you or your child's doctor ever been concerned about any of the following:

	Yes	No	If yes, please explain
Allergies			
Anemia			
Asthma			
Autism			
Behavioral Problems			
Cerebral Palsy			
Cleft Lip/Palate			
Dental Problems			
Developmental Delays			
Ear Tubes / Ear Infections			
Emotional Problems			
Encephalitis			
Epilepsy			
Hearing Problems			
Heart Problems			
Hydrocephalus			
Hyperactivity			
Lead Poisoning			
Major Illness or Injury			
Meningitis			
Mental Retardation			
Seizures			
Tantrums			
Tongue Tied			
Vision Problems			
Voice Problems			
Other:			

IV. DEVELOPMENTAL HISTORY/BEHAVIOR

Please circle when your child reached the following developmental milestones*:

Sitting:	Early (3-6 mos.)	Average (6-9 mos.)	Late (9-12 mos.)	Not Yet	Don't Know
Walking:	Early (7-12 mos.)	Average (12-18 mos.)	Late (over 18 mos.)	Not Yet	Don't Know
Speaking two- to three-word sentences:	Early (1-2 yrs.)	Average (2-3 yrs.)	Late (over 3 yrs.)	Not Yet	Don't Know
Toileting:	Early (1-3 yrs.)	Average (3-4 yrs.)	Late (over 4 yrs.)	Not Yet	Don't Know

*Age-range information from Centers for Disease Control and Prevention (CDC)

Do you have concerns about your child's ability in any of the following areas?

	Yes	No	If yes, please explain
Coordination	______	______	______
Walking	______	______	______
Running	______	______	______
Cutting with Scissors	______	______	______
Using crayon / pencil	______	______	______
Toileting	______	______	______
Eating	______	______	______
Drinking	______	______	______
Sleeping	______	______	______
Behavior	______	______	______
Speech Sounds	______	______	______
Communicating wants/needs	______	______	______
Other:	______	______	______

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

______ Time-out ______ Behavior chart/Rewards system
______ Spanking ______ Extra chores
______ Loss of privileges ______ Grounding

Other (Please describe): ______

How does your child usually react to discipline? ❑ Complies ❑ Complains ❑ Does not comply and resists
❑ Indifferent or passive attitude ❑ Other: ______

IV. DEVELOPMENTAL HISTORY/BEHAVIOR

Please check the following that describe your child:

❑ Caring
❑ Rude/Back-talks
❑ Angry/Hot-tempered
❑ Acts immature for age
❑ Often argues
❑ Physically aggressive
❑ Lies
❑ Steals
❑ Destructive
❑ Moody
❑ Imaginative
❑ Creative
❑ Clowns around
❑ Lazy
❑ Kind
❑ Poor manners
❑ Nervous nature
❑ Shy
❑ Funny
❑ Poor choice of friends
❑ Confident
❑ Excessive energy
❑ Daydreams
❑ Frequently cries
❑ Oversensitive
❑ Generally happy
❑ Generally unhappy
❑ Lacks self-confidence
❑ Perfectionistic
❑ Helpful
❑ Self-destructive
❑ Responsible
❑ Athletic
❑ Independent
❑ Friendly
❑ Poor peer relationships
❑ Good peer relationships
❑ Low energy
❑ Feelings of worthlessness
❑ Talented
❑ Competitive
❑ Lonely/Withdrawn

Has your child participated in any of the following? (check if applicable)

❑ Visits to the library ❑ Visits to the zoo or parks ❑ Church groups or activities
❑ Camps or day programs ❑ Visits to museums or cultural activities ❑ Organized sports

Signed: ______ Date: ______

Relationship to student: ______