**Michigan City Area Schools Special Education Departmen**t

408 S. Carroll Avenue, Michigan City, IN 46360

**Social and Developmental Medical History**

**Student’s Name: DOB: Age:**

**School: Grade: Gender:**

**Home Address: City, State, Zip**

**Phone:**

**School Staff Completing Form: Date form received by School Psychologist:**

**Ethnic Background:** \_\_\_\_\_\_Hispanic/Latino \_\_\_\_\_\_American Indian/Alaskan Native \_\_\_\_\_Asian

\_\_\_\_\_Black/African American \_\_\_\_\_Native Hawaiian/Pacific Islander \_\_\_\_\_White (not Hispanic)

**Person Completing Form**: \_\_\_\_\_Natural Mother \_\_\_\_\_Natural Father \_\_\_\_\_\_Stepmother \_\_\_\_\_Stepfather \_\_\_\_\_Adoptive Parent \_\_\_\_\_Other (Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status of Parents:

If separated or divorced, how old was the child at separation? Divorce?

Who has custody of the child? Does the child have contact with the non-custodial parent?

How often? \_\_\_\_\_Weekly \_\_\_\_\_\_Monthly \_\_\_\_\_\_a few times/year \_\_\_\_\_\_Never

 Is either parent deceased? \_\_\_\_\_Mother \_\_\_\_\_Father If yes, please indicate the year \_\_\_\_\_\_\_\_\_\_

Mother’s name Age Education

 Occupation Phone: Home Business

Father’s name Age Education

 Occupation Phone: Home Business

Stepmother’s name Age Education

 Occupation Phone: Home Business

Stepfather’s name Age Education

 Occupation Phone: Home Business

List all brothers and sisters, or others living with the family and their relationship to the child.

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| --- | --- | --- | --- | --- | --- |
| **Name** | **Age** | **Gender** | **Relationship**  | **Living in Home?** | **Living Outside Home?** |
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Describe the child’s relationship with siblings or others in the home.

Has the student been involved in any of the following settings? If yes, indicate the dates.

Foster Home Group Home Correctional Facility

Other (please specify)

Primary language spoken at home: Other languages spoken at home:

First language learned? If other than English, at what age did your child begin to speak English?

**Student’s Present Performance**

 List your child’s strengths:

List your child’s interests:

Briefly describe your child’s current difficulties.

How long have these problems been of concern to you?

Are there other family members with the same problems? If yes, list name and relation.

Has the child received evaluation or help for the current problem or similar problems?

If yes, list when and with whom.

**Medical History**

Is the child on any medication at this time? If yes, please list below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Taken at Home** | **Taken at School** | **Diagnosis and Reason for Medication** |
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**Check all illnesses or conditions that your child has had:**

\_\_\_\_\_Cancer Age \_\_\_\_\_ \_\_\_\_\_Allergies Age\_\_\_\_\_ \_\_\_\_\_Encephalitis Age\_\_\_\_\_

\_\_\_\_\_Hospitalization Age \_\_\_\_\_ \_\_\_\_\_High Fever Age\_\_\_\_\_ \_\_\_\_Freq/Severe Headaches Age\_\_

\_\_\_\_\_Head Injury Age \_\_\_\_\_ \_\_\_\_\_Asthma Age \_\_\_\_\_ \_\_\_\_\_Unconsciousness Age\_\_\_\_\_

\_\_\_\_\_Operations/Surgery Age \_\_\_\_\_ \_\_\_\_\_Diabetes Age \_\_\_\_\_ \_\_\_\_\_Seizure Activity Age \_\_\_\_\_\_\_

\_\_\_\_\_Meningitis Age \_\_\_\_\_ \_\_\_\_\_Dizziness Age \_\_\_\_\_ \_\_\_\_\_ADD/ADHD Age \_\_\_\_\_

\_\_\_\_\_Bone/Joint Disease Age \_\_\_\_\_ \_\_\_\_\_Broken Bones Age \_\_\_\_\_ \_\_\_\_\_Wetting/Soiling Age \_\_\_\_\_\_

\_\_\_\_\_Sleeping Disorder Age \_\_\_\_\_ \_\_\_\_\_Suicide Attempt Age \_\_\_\_\_ day or night?

\_\_\_\_\_Other (Specifiy) Age \_\_\_\_\_

Other chronic medical conditions?

Please further explain any listed illness or condition.

Name of child’s doctor Address

Date of last physical exam: Does the physician know of the child’s school problems?

Physician’s comments about school problems:

Has the child seen a dentist?

**Family Medical History**

Place an X next to any illness or condition that any family member has had. When you check an item, list the family member’s

 relationship to the child.

\_\_\_\_\_Academic problems \_\_\_\_\_Emotional problems

\_\_\_\_\_Alcoholism \_\_\_\_\_Epilepsy

\_\_\_\_\_Cancer \_\_\_\_\_Heart trouble

\_\_\_\_\_Depression \_\_\_\_\_Neurological disease

\_\_\_\_\_Developmental problems \_\_\_\_\_Suicide Attempt

\_\_\_\_\_Diabetes \_\_\_\_\_Drug problems

\_\_\_\_\_Other medical issues

**Developmental Factors**

**Pregnancy:** Mark if mother had any of the following during pregnancy:

\_\_\_\_\_Hospitalizations \_\_\_\_\_Diabetes \_\_\_\_\_Infectious Diseases (List)

\_\_\_\_\_Convulsions \_\_\_\_\_High Fever \_\_\_\_\_Exposure to X-Rays or chemicals

\_\_\_\_\_German Measles \_\_\_\_\_Medications taken:

**Birth Factors**:

Length of pregnancy Weight at birth Caesarean peformed?

Prolonged, difficult, or forced labor? Birth defects or complications:

Were there any special problems the first month?

**Early Development**: At what age did the child do the following:

Sit alone \_\_\_\_\_\_\_\_\_\_ Speak first words \_\_\_\_\_\_\_\_\_\_ Speak in sentences (2-3 words) \_\_\_\_\_\_\_\_\_\_

Crawl \_\_\_\_\_\_\_\_\_\_ Walk alone \_\_\_\_\_\_\_\_\_\_ Have bladder/bowel control \_\_\_\_\_\_\_\_\_\_

Did the doctor indicate any developmental problems during the child’s first three years of life? If yes, please explain.

**Special Factors**

**Vision Hearing**

\_\_\_\_\_\_No apparent problems \_\_\_\_\_No apparent problems

\_\_\_\_\_Vision examination \_\_\_\_\_Hearing examination

 Date \_\_\_\_\_ By Whom? Date\_\_\_\_\_ By Whom?

\_\_\_\_\_Wears glasses \_\_\_\_\_Had surgery (specify age\_\_\_\_\_)

\_\_\_\_\_Wears contacts \_\_\_\_\_Ear infections/frequency?

\_\_\_\_\_Had surgery (specify Age \_\_\_\_\_) \_\_\_\_\_Hearing loss/Age of loss \_\_\_\_\_

**Gross and Fine Motor Communication**

\_\_\_\_\_No apparent problems \_\_\_\_\_No apparent problems

\_\_\_\_\_OT or PT Examination \_\_\_\_\_Speech/Language evaluation

Date \_\_\_\_\_ By Whom? Date\_\_\_\_\_ By Whom?

\_\_\_\_\_Walking, jumping, running problems \_\_\_\_\_Problems expressing thoughts

\_\_\_\_\_Cutting, writing, coloring, printing problems \_\_\_\_\_Problems pronouncing words

\_\_\_\_\_Coordination of feeding and dressing \_\_\_\_\_Initiates and sustains conversation

\_\_\_\_\_Repetitive use of language \_\_\_\_\_Sustains eye contact

\_\_\_\_\_Hand dominance \_\_\_\_\_Other (Specify)

\_\_\_\_\_Other (Specify)

**Social**

How does your child interact with other children? (list any fights, play groups, friends, trouble, etc.)

How does your child get along with adults?

Have you noticed any unusual social interactions such as non-functional ritual routines, lack of social awareness (private or

public)? If yes, please explain.

**School History:**

**Grade Level Name of School Location\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Early Childhood Care: \_\_\_\_\_Nursery School \_\_\_\_\_Family Daycare \_\_\_\_\_Daycare Center \_\_\_\_\_Babysitter in home

Has your child been absent from school a lot? If yes, explain.

**School Interventions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Interventions the child has received** | **Yes** | **No** | **Grades** | **Comments** |
|  Repeated grade |  |  |  |  |
| Reading Assistance |  |  |  |  |
| Remediation |  |  |  |  |
| Speech/Language |  |  |  |  |
| Counseling/Social Services |  |  |  |  |
| Suspension/Expulsion |  |  |  |  |
| Summer School |  |  |  |  |
| Other (Specify) |  |  |  |  |

**Agency Services**

|  |  |  |
| --- | --- | --- |
| **Agencies that have provided services for the child** | **Dates** | **Reasons (please give as much detail as possible)** |
| Private tutoring/First Steps |  |  |
| Private Counselor/Therapist (specify) |  |  |
| Community Service Agency (specify) |  |  |
| Mental Health Agency |  |  |
| Department of Children and Families |  |  |
| Court System |  |  |
| Day Treatment Program (specify) |  |  |
| Inpatient Psychiatric Hospital (specify) |  |  |

What do you think your child needs to do that s/he is not doing now and why?

Do you have any other questions or concerns?

Any other information that would help us understand your child?