Michigan City Area Schools Special Education Department
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.

Name	Age	Gender	Relationship	Living in Home?	Living Outside Home?

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

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

_____No apparent problems

_____Vision examination

Date _____ By Whom?

_____Wears glasses

_____Wears contacts

_____Had surgery (specify Age _____)

Hearing

_____No apparent problems

_____Hearing examination

Date_____ By Whom?

_____Had surgery (specify age_____)

_____Ear infections/frequency?

_____Hearing loss/Age of loss _____

Gross and Fine Motor

_____No apparent problems

_____OT or PT Examination

Date _____ By Whom?

_____Walking, jumping, running problems

_____Cutting, writing, coloring, printing problems

_____Coordination of feeding and dressing

_____Repetitive use of language

_____Hand dominance

_____Other (Specify)

Communication

_____No apparent problems

_____Speech/Language evaluation

Date_____ By Whom?

_____Problems expressing thoughts

_____Problems pronouncing words

_____Initiates and sustains conversation

_____Sustains eye contact

_____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**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?