Preschool Social History/Parent Review

Date of Screening: _____ **Home School:** ANT CB CCR FK8 MR SR STH WB
Child Name: _____ **Date of Birth:** _____
Address: _____ **CITY:** _____ **ZIP:** _____
Language spoken by the Child_____**Dominant language spoken at home:** _____

Mother's relationship to student: (Circle one) Natural Step Guardian Foster
Mother's name: _____ **PHONE NUMBER:** _____
Primary Language Spoken: _____ **EMAIL ADDRESS:** _____

Father's relationship to student: (Circle one) Natural Step Guardian Foster
Father's name: _____ **PHONE NUMBER:** _____
Primary Language Spoken: _____ **EMAIL ADDRESS:** _____

Parent request summary in native language: ___ Yes ___ No

Foster Agency: _____
Address: _____
Caseworker: _____ **Telephone:** _____

Referral source: (who referred the family?)
Self-referral Daycare Foster Agency Hospital/Pediatrician School District
Early Intervention Program other: _____
Reason for referral: _____
_____
_____
Parent's view of the problem: _____
_____
_____

HOME/FAMILY ENVIRONMENT

Family resides in: House Apartment Other: _____
Child sleeps in: Crib Bed Toddler bed Shares bed Shares bedroom

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Marital Status of bio-parents: _____ Estranged Parent: YES/NO
If divorced, please provide a copy of Parenting Plan, specifically the portion that addresses Legal Decision Making. Parenting plan must have signature of both biological parents and be notarized..

History of developmental delays in the family (please provide diagnosis and relationship to student):
_____
_____

Student: _____ DOB: _____

LIST ALL PEOPLE THAT RESIDE IN THE HOME (PARENT, CHILDREN, STEP CHILDREN, AND OTHERS):

Name	Relationship	Age	Grade/ Profession	Highest Level of Education

Siblings not living in the home: _____

_____

EDUCATIONAL HISTORY

Has your child been evaluated previously: YES/NO

Type of evaluation (check all that apply):

___ Educational
___ Occupational Therapy
___ Audiological
___ Medical (Neurology)
___ Psychological
___ Physical Therapy
___ Speech/Language
___ Developmental Pediatrician

Has your child previously attended a program:

Day-care Play group Pre-K Early Intervention Babysitter HeadStart

Name of program: _____ Phone number: _____

Address: _____ Service coordinator/Teacher: _____

Previous Services:

Service	Frequency	Provider	Duration

Has your child ever had an IEP at a previous district? YES/NO If so, where: _____

_____

Student: _____ DOB: _____

BIRTH HISTORY

Prenatal care: YES/NO

Exposure drugs/alcohol/cigarettes during pregnancy: YES/NO

If YES, please provide additional information: _____

City/State/Country of birth: _____

Name of hospital for delivery: _____

Type of Delivery: ____Vaginal ____C-Section If C-Section – reason: _____

Birth: ____Full term _____Pre-term Gestational Age of infant at birth: _____

Birth weight: _____lbs _____ ozs Birth Length: _____inches

Toxicology of infant at birth: ___N/A ____Positive ____Negative

Medical complications for the MOTHER pregnancy:

____None ____High Blood Pressure ____Gestational Diabetes ____Spotting ____Other:_____

Medical complications for the CHILD at birth:

____None ____Jaundice ____Photo Therapy ____Incubator ____Oxygen ____Feeding issues

____Other: _____

Length of hospital stay: _____Follow up care at discharge: _____

MEDICAL HISTORY

Current weight: _____ Current height: _____

Diagnosis: _____ Date or age of diagnosis: _____

Hearing aids: YES/NO Glasses: YES/NO Leg braces: YES/NO Assistive equipment: YES/NO

If YES on any of the above, please explain: _____

Newborn hearing screening: YES/NO Date: _____ Results: PASS/FAIL

Audiological Exam: YES/NO Date: _____ Results: _____

Vision Test: YES/NO Date: _____ Results: _____

Immunization status: _____

Hospitalizations: YES/NO If YES, please explain:

Date	Length of stay	Purpose	What Hospital

Student: _____ DOB: _____

Previous Surgery: YES/NO If YES, please explain:

Date	In-patient/ Outpatient	Purpose	What Hospital

Respiratory problems: YES/NO If YES, please explain: _____

Allergies: YES/NO If YES, please explain: _____

Ear Infections: YES/NO If YES, please explain: _____

Medications: YES/NO If YES, please explain (name, dosage, frequency): _____

_____

Pediatrician: _____ Name of clinic: _____

Address: _____ Phone: _____

DEVELOPMENTAL HISTORY

Motor Skills **Language Skills**

Developmental Skill	Age of Development (in months)		Developmental Skill	Age of Development (in months)
Head control			Babbles	
Rolled Over			Spoke First Word	
Sat independently			Imitated sounds or words	
Crawled			Began using 2-word Phrases	
Walked independently			Spoke in 3-4 word sentences	

Functional Motor Skills

Do you have any concerns with your child's gross motor skills (running, jumping, climbing, etc)? YES/NO

If YES, please explain: _____

_____

Do you have any concerns with your child's fine motor skills (holding markers, picking up small objects, etc)? YES/NO

If YES, please explain: _____

Student: _____ DOB: _____

_____

Functional Communication Skills

Do you have any concerns with your child's ability to understand language (follow directions, understand vocabulary, answer questions, etc.)? YES/NO

If YES, please explain: _____

_____

Do you have any concerns with your child's ability to use language (label vocabulary, make requests/comments, etc.)? YES/NO

If YES, please explain: _____

_____

Do you have any concerns with your child's ability to use clear articulation (difficulty say specific sounds, hard for others to understand, etc.)? YES/NO

If YES, please explain: _____

_____

Functional Learning Skills

Do you have any concerns with your child's attention? YES/NO

If YES, please explain: _____

_____

Do you have any concerns with your child learning new concepts? YES/NO

If YES, please explain: _____

_____

Social Emotional Skills

Do you have any concerns with your child's social skills (getting along with parents, caregivers, peers, and his/her ability to manage emotions)? YES/NO

If YES, please explain: _____

_____

Adaptive Skills

Do you have any concerns with your child's independent self-help skills to include toileting, feeding, dressing, and personal responsibility ?YES/NO

If YES, please explain: _____

_____