

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

Charlotte-Mecklenburg Schools

The information gathered on this form can be used when writing a Social/Developmental History.

I. GENERAL INFORMATION

Child's full name _____ Grade _____ Age _____ DOB _____

Current Address: _____ How long at this address? _____

Person providing information: _____ Relationship to child _____

Who does child live with: both parents mother father other (specify) _____

Biological father _____ Occupation _____ Years education: _____

Father's home phone _____ Work # _____ Cell # _____

Biological mother _____ Occupation _____ Years education: _____

Mother's home phone _____ Work # _____ Cell # _____

N/A Guardian's name _____ Occupation _____ Years education _____

Guardian's home phone _____ Work # _____ Cell # _____

Please list all people in child's immediate family:

Name	Relationship to child	Age / Grade	Living in house?

Please list all other *non-family* members who live in household:

Name	Relationship to child/family	How long has lived in household?

Language(s) spoken at home _____ Primary Language at home _____

Please list all locations (city, state) that your child has lived:

- | | |
|---------------------|--------------------------|
| 1. Birthplace _____ | Moved at age/grade _____ |
| 2. _____ | Moved at age/grade _____ |
| 3. _____ | Moved at age/grade _____ |
| 4. _____ | Moved at age/grade _____ |

Are biological parents of child currently: married separated divorced never married

• If separated or divorced, who has *legal* custody? mother father other (specify): _____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

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.) _____

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)

What do you feel are your child's...

Strengths _____

Weaknesses _____

Briefly describe your concerns for your child.

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is child your: biological child adopted child foster child other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? Yes No

Please specify any medications used during pregnancy and the reason used: _____

Pregnancy lasted _____ weeks / months Child's birth weight: _____ pounds _____ ounces

APGAR score ...at 1 minute _____ ...at 5 minutes _____ Unsure / Don't know

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

If No, explain why: _____

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

Mother's Pregnancy

- No Complications
- Blackouts
- Falls
- Physical Injury
- Blackouts
- Excessive Bleeding
- Hypertension
- Diabetes
- Emotional Stress
- Toxemia
- Alcohol/Drug Use
- Use of Tobacco

Child's Delivery

- Normal
 - Induced Labor
 - C-Section
 - Breech birth
 - Unusually long labor (>12 hrs)
 - Premature # of weeks _____
 - Overdue # of weeks _____
 - Other Problem (Specify) _____
- _____
- _____
- _____

Child's Condition at Birth

- Normal / No problems
 - Lack of Oxygen
 - Breathing Problem
 - Birth Injury/Defect:
 - Jaundice
 - Newborn ICU # of days _____
 - Other Problem (Specify) _____
- _____
- _____
- _____

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: _____

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

If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? Yes No

If "yes," by whom (professional/agency) and when: _____

Has your child had any of the following?	Please describe and give details, dates, and/or age onset
<input type="checkbox"/> Serious Illnesses	
<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Surgery/Hospitalization	
<input type="checkbox"/> History of Ear Infections	
<input type="checkbox"/> Allergies and/or Asthma	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Frequent Nightmares and/or Bedwetting	
<input type="checkbox"/> Other health problem:	

Is there a <i>family history</i> for the following problems?	<i>Biological</i> family member with the history ... (parent, sister/brother, aunt/uncle, grandparent, 1 st cousin, etc)
<input type="checkbox"/> Learning Difficulties (reading, math, writing, spelling)	
<input type="checkbox"/> Speech or Language problem (articulation, stuttering, etc.)	
<input type="checkbox"/> Developmental Disorder (such as Autism, Aspergers, etc.)	
<input type="checkbox"/> Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> School Failure (failing grades, dropout, etc)	
<input type="checkbox"/> Drug or Alcohol Addiction	

C. Development

Please indicate the age or age range when your child performed the following milestones:

Milestone:	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke short phrases							
Spoke 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?

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

* If checked any above, please describe _____

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

❖ Activity Level – How active has your child been from an early age?

❖ Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

❖ Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way?

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

❖ 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.?

❖ Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament?

❖ Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.?

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

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

C. Differential Behaviors

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

- | | |
|---|--|
| <input type="checkbox"/> Destructive behavior | <input type="checkbox"/> Appears depressed & unhappy much of the time |
| <input type="checkbox"/> Is affectionate with family and friends | <input type="checkbox"/> Explosive temperament |
| <input type="checkbox"/> Responds well to authority figures | <input type="checkbox"/> Frequently complains about aches and pains |
| <input type="checkbox"/> Boundless energy and poor judgment | <input type="checkbox"/> Appears to have low self-esteem |
| <input type="checkbox"/> Withdrawn and/or sullen | <input type="checkbox"/> Prefers to be alone (or considers self “a loner”) |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Starts fires |
| <input type="checkbox"/> Disorganized, loses things often | <input type="checkbox"/> Lacks motivation |
| <input type="checkbox"/> Shows sudden outburst of physical aggression | <input type="checkbox"/> Steals or lies |
| <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Becomes upset with change |
| <input type="checkbox"/> Shifts from one activity to another | <input type="checkbox"/> Fearfulness |
| <input type="checkbox"/> Has difficulty playing quietly | <input type="checkbox"/> Frequent peer and/or family conflicts |
| <input type="checkbox"/> Requires a lot of parent attention | <input type="checkbox"/> Does not appear to listen to what is being said |
| <input type="checkbox"/> Fidgets or squirms in seat | <input type="checkbox"/> Always worrying about something |
| <input type="checkbox"/> Appears to daydream or “zone out” often | <input type="checkbox"/> Nervous habits (nail biting, hair twirling, etc.) |

D. Home Behavior:

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

*Problems include: doesn't follow directions/rule, needs reminders, arguments/fights, whines/cries, fidgets/squirms, etc.

- | | | | |
|---|---------------------------------|------------------------------------|-------------------------------------|
| • While getting ready for school... | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When eating at the dinner table | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When playing by him/herself | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When playing with siblings / children in neighborhood... | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When with a babysitter or at daycare... | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • In public places where needs to behave (church, store, etc) | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When in the car... | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When told to do something he/she doesn't want to do | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • During sit-sown homework time... | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| • When watching TV or playing a video game | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

How would you describe your child's personality at home?

How does your child get along with brothers/sisters? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* that your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.) _____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

Does your child do these regularly? Yes No Does your child need frequent reminders? Yes No

Indicate child's... Bed time? ____:____PM Wake time? ____:____AM Does child sleep well? _____

How much time does your child typically spend on electronic media?

Watching T V: ____hrs/day; Playing video/computer games: ____hrs/day; Other _____: ____hrs/day

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

Explain: _____

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?)

How does your child interact with children in the neighborhood?

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

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

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

If yes, which program and when services begin _____

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

Preschool / Daycare _____

Elementary School _____

Middle School _____

High School _____
