CENTER SOCIAL DEVELOPMENTAL HISTORY

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| Child’s Information |
|  |
| Legal Name: | Child’s Legal Name | Preferred Name: | Child Preferred Name |
| Birth Date: | Birth Date | Gender: | Gender | Age: | Age | Grade: | Grade |
| School: | Full Name of School | Teacher: | Teacher |
| Parent Name: | Parent(s) Name(s) |
| Home Address: | Street Address | City: | City | Zip Code: | Zip Code |
| Phone: | Phone Number | Choose | Parent email: | Parent email |
|  |
| How does your child usually communicate with you (check all that apply)? |
| [ ] Gestures/pointing [ ] Single words [ ] Short phrases [ ] Sentences [ ] Single signs [ ] Signed phrases |
| [ ] ASL sentences [ ] Pantomime [ ] Signed English sentences [ ] Cued speech  |
| [ ] Other: | Other ways your child communicates with you |
|  |  |
| How do you communicate with your child? | How you communicate with your child |
|  |
| Language(s) used within the home (please check all that apply): |
| [ ] Spoken English [ ] Spoken Spanish [ ] Sign Language [ ] Other: | Other Language(s) |
|  |  |  |
| Is this referral related to any type of legal or court proceeding?  | If yes, explain |
| Is this referral related to a potential change in educational placement? | If yes, explain |
|  |  |  |
| What do you enjoy most about your child? |  |  |
| Explain |
| What do you find most challenging about raising your child? |  |  |
| Explain |
| What would you like to see, or what do you see, your son/daughter doing after high school? |
| Explain |
| What level of education do you hope your child will complete? Choose an item |

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| Family Information |
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| Child is living with: | [ ] Both Parents [ ] Mother [ ] Father [ ] Mother and Stepfather |
|  | [ ] Father and Stepmother [ ] Legal Guardian [ ] Other:  | Other |
| Is the child adopted? Select If yes, child’s age at adoption:  | Age |
| Parental marital status: Select Marital Status  |
| If parents are separated or divorced, who has custody of this child?  | Custody |
| How often does the other parent see this child? Select frequency of visitation |

 Other Children (Including step-siblings and half siblings): [ ] No other children/siblings

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| --- | --- | --- | --- | --- | --- |
| Name | Gender | Age | Relationship to Student | In home | School/behavioral/health Problems |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |

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| If any other individuals are living in the home, please list their names and relationship to the student |
| here: | Name; Relationship to child |
| Any special living circumstances or recent changes that may impact your child? Select |
| Explain: | Explain |

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| --- | --- | --- | --- | --- |
|  | Birth Mother | Birth Father | Adoptive Mother, Stepmother, Legal Guardian, etc. | Adoptive Father, Stepfather, Legal Guardian, etc. |
| NAME: | Name | Name | Name | Name |
| Highest grade completed **or** Degree: | Education Level | Education Level | Education Level | Education Level |
| Occupation: | Occupation | Occupation | Occupation | Occupation |
| Learning difficulties | Select | Select | Select | Select |
| Psychological or psychiatric problems | Select | Select | Select | Select |
| ADHD | Select | Select | Select | Select |

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| Biological Extended Family |
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| Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) have:  |
| [ ] ADHD; specify who: | Who |
| [ ] Epilepsy; specify who: | Who |
| [ ] Seizures; specify who: | Who |
| [ ] Alcoholism or substance abuse; specify who: | Who |
| [ ] Psychological/emotional/personality difficulty; specify who: | Who |
| [ ] Learning problems/differences; specify who:  | Who |
| [ ] Cognitive or Developmental challenges; specify who: | Who |
| [ ] Neurological disorder; specify who: | Who  |
| [ ] Other; please list: | Other challenges | Specify who: | Who |

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| Developmental Information |
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| At what age did this child first do the following? (Please indicate year or month of age for each) |
| Turn over | Age | Sit alone  | Age | Crawl | Age | Stand alone | Age | Walk alone | Age |
| Walk downstairs | Age | Walk upstairs | Age | Toilet trained days | Age | Toilet trained nights | Age |
| Did your child: [ ] Belly crawl [ ] Crawl on hands and knees [ ] Did not crawl  |
| Did accidents occur after toilet training:  |  |  |
|  Soiling (encopresis)? Select If yes, until what age | Age |
|  Wetting (enuresis)? Select If yes, until what age | Age |
| Medical reasons for toileting accidents? Select reason: | Reason |

Did/Does your child have:

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| --- | --- | --- | --- |
| Motor Difficulties (walking, skipping, catching, riding a bike) | Select | Describe: Explain | What age(s): Age(s) |
| Sleeping Problems | Select | Describe: Explain | What age(s): Age(s) |
| Difficulty Separating From Parents | Select | Describe: Explain | What age(s): Age(s) |
| Excessive Crying | Select | Describe: Explain | What age(s):Age(s) |
| Over/Underweight (or Failure to Thrive) | Select | Describe: Explain | What age(s): Age(s) |
| Feeding Problems | Select | Describe: Explain | What age(s): Age(s) |

Please list any unusual, traumatic, or possible stressful events in the child’s life that you think may have had an impact on his/her development/current functioning: [ ] NONE [ ] UNKNOWN

|  |  |  |
| --- | --- | --- |
| Event | Age of child at event | Comments |
| Event | Age | Explain |
| Event | Age | Explain |
| Event | Age | Explain |

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| Sensory Processing Information |
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| Indicate if your child has any atypical response to the following (please give examples): |
| [ ] Touch (i.e., does not like light touch, needs deep pressure hugs, etc.): |
| Explain |
| [ ] Taste (i.e., does not like slimy, prefers sweet or spicy, avoids food with textures, etc.): |
| Explain |
| [ ] Texture (i.e., avoids or seeks rough, slimy, sticky, gel, satin, etc.): |
| Explain |
| [ ] Movement (i.e., becomes overly excited with movement, swinging calms them down, etc.): |
| Explain |
| [ ] Limited food intake (i.e., list specific likes or dislikes, picky eater, etc.): |
| Explain |
| [ ] Environmental (i.e., easily overstimulated in stores or restaurants): |
| Explain |
| Additional Sensory Comments:  | Additional Sensory Information |
|  |
| Please indicate whether this child exhibits any of the following behaviors: |
| [ ] Overreacts when faced with a problem | [ ] Seems impulsive | [ ] Easily overstimulated |
| [ ] Seems overly energetic in play | [ ] Lacks self-control | [ ] Short attention span |
| [ ] Seems uncomfortable meeting new people | [ ] Seems unhappy | [ ] Withholds affection |
| [ ] Needs significant parental attention | [ ] Hides feelings | [ ] Cannot calm down |
| [ ] Has unusual fears; what: | List the unusual fears |
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| What upsets or frustrates your child? | List what upsets your child |
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| Please describe any behaviors that are particularly concerning to you or others: |
| Concerning behaviors |

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| Pregnancy Information |
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| Was the child’s mother under the care of a doctor or midwife? Select |
| Check any of the following complications that occurred during pregnancy: |
| [ ] Anemia  | [ ] Excessive vomiting  | [ ] Rh incompatibility |
| [ ] Cytomegalovirus  | [ ] Flu/cold | [ ] Toxemia |
| [ ] Emotional problems | [ ] High blood pressure | [ ] Vaginal bleeding |
| [ ] Excessive swelling | [ ] Measles  | [ ] Virus (e.g., Zika, H1N1) |
| [ ] Other:  | Other medical issues not listed |
| Maternal injury:  | Select If yes, describe: | Describe injury |
| Hospitalization during pregnancy:  | Select If yes, reason: | Reason for hospital stay |
| Medications during pregnancy:  | Select If yes, describe: | Prescribed medications |
| Alcohol during pregnancy:  | Select If yes, frequency: | Frequency |
| Cigarettes used during pregnancy: | Select If yes, frequency: | Frequency |

Other drugs used during pregnancy: Select If yes, describe below:

|  |  |  |
| --- | --- | --- |
| Type of drug | Frequency | Prescription |
| Type of drug | How often taken | Select |
| Type of drug | How often taken | Select |
|  |
| Birth Information |
|  |
| [ ] Check here if you have limited information pertaining to birth history and proceed to the *Additional Medical Information* section below  |
|  |
| Where was the child born? (hospital, city) |  Birth Hospital, City where located |
| Length of pregnancy: |  Length | weeks | Birth weight: | Weight | lbs. | Weight | oz. |
| Child’s condition at birth: | Select status | Mother’s condition at birth: | Select status |
|  |
| Check any of the following complications that occurred during/just after birth: |
| [ ] Breech birth | [ ] Caesarean delivery | [ ] Forceps used | [ ] Labor induced |
| [ ] Other delivery complications, describe: | Explain |
| [ ] Incubator: how long? | Length of time in an incubator |
| [ ] Jaundiced | [ ] Bilirubin lights:  | How long under lights? | Length of time under bilirubin lights |
| [ ] Breathing problems right after birth, describe: | Explain breathing problems |
| [ ] Supplemental oxygen: How long? | Length of time on supplemental oxygen |
| [ ] Sent to NICU: How long was stay? | Length of stay in NICU and/or PICU |
| [ ] NO COMPLICATIONS DURING/AFTER BIRTH |
| Any medical diagnosis at birth? Select If yes: | List birthmedical diagnoses |
| List all medical diagnoses given in infancy: | Additional medical diagnoses in infancy |

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| Additional Medical Information |
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| The child’s current health is: Choose health status  |
| Child had a head injury? Select | Lose consciousness? Select |
| How long? | Length of time | Comatose? Select If yes, how long? | Length of time |
| Has the child ever had a neurological exam? Select If yes, exam date: | Exam Date |
| Neurologist’s Name: | Doctor Name | City: | City |
| Reason for Exam: | Reason for neurological exam |
| List all medical diagnoses the child has been given to date: | All diagnoses to date |
| Has any genetic testing been conducted? Select By whom: | Doctor name |
| Results: | Results of genetic testing |
| Date of last vision test: | Date | Prescription eyewear? [ ] Glasses [ ] Contacts [ ] None |
| Reason for vision testing and/or prescription: | Vision Information |
| Has your child’s information been shared with the DeafBlind Registry? Select |
| Is your child being tested for any other concerns? Select | List concerns |

Please list any prescription medications currently being taken by the child

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Times Per Day Taken  | Reason |
| Medication Name | Dosage | Doses per day | Reason for prescription |
| Medication Name | Dosage | Doses per day | Reason for prescription |
| Medication Name | Dosage | Doses per day | Reason for prescription |

Surgeries and/or hospitalizations (please list **ALL**):

|  |  |  |  |
| --- | --- | --- | --- |
| Description or Name of surgery/hospitalization | Age of child | Length of hospital stay | Reason |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |

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| **Audiological Information** |
|  |
| Did child pass the Universal Newborn Hearing Screening? Select  |
| Age at which hearing loss was identified by an audiologist:  | Age identified by audiologist |
| Has a cause been determined for your child’s hearing loss?  | Select |
| Cause: | Cause of hearing loss |
| When was your child’s last hearing test? | Date | Where? | Location |
| Would you describe the child’s hearing loss as: Choose description  |
| Has the child had any genetic testing related to the hearing loss? | Select |
| Results: | Results of testing |
| Does the child have a history of ear infections?  | Select |
| If, YES: First occurrence: | Date | Frequency: | How often | Most recent: | Date |
| Treatment(s): | Describe treatment(s) |
| Has the child ever had ear tubes (PE tubes) surgically inserted? Select When: | Date |
| Second set date: | Date | [ ] None |
| Third set date: | Date | [ ] None |

Please complete the following amplification table:

|  |  |  |  |
| --- | --- | --- | --- |
| Technology |  | Age Received | Currently Use |
| Hearing aid **Right** ear  | Select | Age | Select |
| Hearing aid **Left** ear | Select | Age | Select |
| Cochlear Implant **Right** side | Select | Age | Select |
| Cochlear Implant **Left** side | Select | Age | Select |
| BAHA **Right** side | Select | Age | Select |
| BAHA **Left** side | Select | Age | Select |
| FM/DM system | Select | Age | Select |

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| --- | --- | --- | --- | --- |
| If your child has cochlear implant(s) or BAHA(s) when was the surgery? | 1st | Date | 2nd | Date |
| Activation?  | 1st | Date | 2nd | Date |
| Any revisions to implant(s)? Select If yes, when:  | Date |
| Reason for revision: | Reason for revision |
|  |
| How many hours each day does the child use amplification? Choose hours per day amplification use |
|  |
| With amplification, describe your child’s listening skills: | Describe |
| Does your child regularly see an audiologist/clinic for hearing and device checks? Select |
| If yes, who/where: | Name of audiologist/location of office |
| Please check all medical conditions that apply (indicate right ear, left ear, or both): |
|  | [ ] Dizziness or unsteadiness  |
|   | [ ] Ear deformity  | Select to specify ear |
|   | [ ] Ear drainage  | Select to specify ear |
|  | [ ] Ear pain/ earaches  | Select to specify ear |
|  | [ ] History of ear wax build up  | Select to specify ear |
|  | [ ] Tinnitus/ringing/noises in ears  | Select to specify ear |
|  | [ ] Other: | Other ear-related medical issues |
|   | [ ] NO AUDIOLOGICALLY-RELATED MEDICAL CONDITIONS TO DATE |

Are there Deaf or hard of hearing family members? Select

|  |  |  |
| --- | --- | --- |
| Family Member | Relationship to child | Age of onset for hearing loss |
| Name | Relationship to child | Age |
| Name | Relationship to child | Age |
| Name | Relationship to child | Age |

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| Language Information |
|  |
| Approximately how much of your child’s communication do you understand? Select estimate |
| Approximately how much of your child’s communication do others outside of family understand? |
| Select estimate |
| Is your child using any form of alternative/augmentative comm. (e.g., tech, pictures)? Select |
| What system? | Name of AAC system |
|  |
| Did speech development ever seem to stop/ regress for a period of time? | Select |
| Does the child seem to understand what you say/sign to him or her?  | Select |
| Does your child consistently answer to his/her name?  | Select |
| Does your child make appropriate eye contact with others?  | Select |
| Does your child follow simple commands?  | Select |
| Does your child ever have trouble remembering what you have told them? | Select |

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| Behavioral and Mental Health Information |
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| Has the child ever had a psychological or psychiatric exam? Select |
| Doctor’s name:  | Doctor Name | City: | City | Date of Exam: | Date |
| Reason for Exam: | Reason for exam |
|  |
| Child ever been diagnosed by a psychologist/physician/other professional? (ADHD, Anxiety, etc.)  |
| Select If yes, what/when: | Diagnosis/when |

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? Select If yes (please complete below chart)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mental Health Treatment | Type of counseling | Age of student during treatment | Name of Agency/ Counselor | Length of treatment |
| Treatment | Select type | Age | Name | Length |
| Treatment | Select type | Age | Name | Length |
| Treatment | Select type | Age | Name | Length |

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| Educational Information |

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that the child is receiving/ has received (school and private): [ ] Did not receive services [ ] Unknown

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of Therapy | Therapist | Frequency | Place(Private/school) | Group or Individual | Duration(e.g., age 3-5) |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |

List **all** previous school and grades attended:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of School | City, State | Grades Attended | Academic Concerns | Modified Curriculum | Special Education Services | RTI/MTSS, 504, IEP, Resource, etc. |
| School | Location | Grade(s) | Select | Select | Select | Services received |
| School | Location | Grade(s) | Select | Select | Select | Services received |
| School | Location | Grade(s) | Select | Select | Select | Services received |
| School | Location | Grade(s) | Select | Select | Select | Services received |
| School | Location | Grade(s) | Select | Select | Select | Services received |
| Has the student been retained? Select If yes, grade(s): | Grades repeated |
| Did your child receive early intervention services? Select |
| Please list all therapy received while enrolled in early intervention: |
| Type of Therapy | Therapist | Frequency | Duration(e.g., 12 mos. – 24 mos.) |
| Type | Name | How often | Age received service |
| Type | Name | How often | Age received service |
| Type | Name | How often | Age received service |
| Type | Name | How often | Age received service |

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| --- | --- |
| Are there other Deaf or hard of hearing children at the current school?  | Select |
| Any Deaf or hard of hearing children in your community?  | Select |
|  |
| Additional information you would you like us to know: (additional concerns, child’s interests, etc.) |
| Additional information |
| Additional information |
| Additional information |
| Additional information |
| Additional information |
| Additional information |
| Additional information |
|  |  |  |  |
| Signature: | Name of person filling out form | Date: | Date |
| Relationship to child: | Relationship to child |
| *If you are the legal guardian, please provide a copy of the court/legal documents.* |