Date Completed:________________

Crook County School District

Where Students Dream, Learn, & Succeed

INSTRUCTIONAL SERVICES
471 NE Ochoco Plaza Drive
Prineville,OR 97754
541-447-3743

DEVELOPMENTAL HISTORY FORM

(A questionnaire for school planning)

Name of Student: DOB: Gender: ☐ M ☐ F

School: Teacher: Grade:

Address: Zip Code:

Home Phone: Alt Phone: Email:

Primary Language of Child: Primary Language at Home:

Questionnaire completed by Name: Relationship:

Informant (If different from above) Name: Relationship:

FAMILY:

Adult's name with whom the child is living: Age:

❑ Natural Mother	❑ How Long?	❑ Adoptive Mother	❑ How Long?
❑ Natural Father	❑ How Long?	❑ Adoptive Father	❑ How Long?
❑ Stepmother	❑ How Long?	❑ Foster Mother	❑ How Long?
❑ Stepfather	❑ How Long?	❑ Foster Father	❑ How Long?
❑ Other (Specify)			

People living in the home (including parents and other adults):

NAME	AGE	GENDER		RELATIONSHIP TO CHILD
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	

Describe how the other children get along in school:

Who is your child's medical doctor?

Health:	❑ None	❑ Private
Insurance:	❑ Oregon Health Plan (OHP)#	❑ Other

Is the child currently under medication or treatment? If yes, explain.

Have there been any recent disruptions in the family?

Check any issues below your child has been exposed to:

- ❑ divorce
- ❑ alcoholism
- ❑ drug abuse
- ❑ foster care
- ❑ domestic violence
- ❑ chronic major illness
- ❑ mental illness
- ❑ major surgery
- ❑ violence
- ❑ pregnancy
- ❑ rape
- ❑ death
- ❑ sexual abuse
- ❑ physical abuse
- ❑ head injury
- ❑ unemployment
- ❑ homelessness
- ❑ poverty
- ❑ imprisonment
- ❑ frequent moves

COMPLETE FULL CASE HISTORY FOR INITIAL. Complete pages 1 & 4 for 3 YEAR EVALUATION.

HISTORY OF PREGNANCY

While pregnant with this child, was the Mother under a doctor's care? ____________________

Check and describe any of the following you had during pregnancy:

	Bleeding
	Diabetes
	Elevated Blood Pressure
	Stress/Emotional Problems
	Injury/Accident
	List any illnesses you had or were exposed to during pregnancy:

While you were pregnant, was the baby exposed to any of the following:

- ❑ Alcohol ❑ Drugs ❑ Nicotine ❑ Caffeine ❑ Medications ❑ Toxins

BIRTH HISTORY

Mother's age at time of birth:	Baby's weight:	Baby's length:

YES	NO	(If yes, please specify)
		Was baby premature? If yes, how early?
		Did you have twins? If yes, which was born first?
		Was labor induced?
		Were you given medication during labor? If yes, what kind?
		Was the birth Cesarean?
		Was the labor and/or delivery unusual in any way? If yes, explain.
		Were forceps or suction used in the delivery?
		Did the baby have breathing problems?
		Did the baby have the cord around the neck?
		Was the baby quick to cry?
		Was the baby' color abnormal? If yes, was it: ☐ Blue ☐ Yellow
		Was oxygen used for the baby? If yes, for how long?
		Did you go home from the hospital before the baby? If yes, how much longer did the baby stay in the hospital?
		Did you have problems feeding the baby? If yes, explain.

EARLY DEVELOPMENT (fill in the best you can remember)

Age walked alone:	Age said first word:	Did child like to be cuddled as a baby? ☐ Yes ☐ No
Age toilet trained during night:		Age toilet trained during day:

SOCIALIZATION

Check any of the characteristics which applied to your child during the infant and early years of development;

- ❑ Shy or timid
- ❑ Hit, hurt or was aggressive to other children
- ❑ Bed wetting
- ❑ Didn't seem as aware to dangers as most other children
- ❑ Expressed lots of affection
- ❑ More interested in things than people
- ❑ Temper tantrums
- ❑ Very active, into things more than others, restless
- ❑ Breath holding
- ❑ Verbalized and talked a lot when learned how
- ❑ Daredevil behaviors
- ❑ Played well with others
- ❑ Unusual fears
- ❑ Had fewer interests than most children
- ❑ Rocking
- ❑ Highly interested and curious as a child
- ❑ Head bumping
- ❑ Very cooperative and easy to be around as a child
- ❑ Cried more than others
- ❑ Liked lots of physical attention as a child
- ❑ Wanted to be left alone
- ❑ Seemed immature when compared to other children
- ❑ Somewhat spoiled
- ❑ Less active than most children
- ❑ Difficult to make him/her mind
- ❑ Didn't seem to get along with others
- ❑ Other ____________________

PHYSICAL/MEDICAL HISTORY:

YES	NO	PROBLEM	DATE OF LAST EXAM	BY WHOM
		Dental		
		Vision		
		Hearing		

CHECK ALL THAT APPLY:

✓		AGE	DESCRIBE
	High fevers (103 to 104)		
	Seizures/convulsions		
	Injuries to head		
	Fainting spells/unconsciousness		
	Major injuries		
	Hospitalizations		
	Operations		
	Throat infections		
	Ear infections		
	Pneumonia		
	Eating problems		
	Sleep problems/nightmares/snoring		
	Toileting		
	Emergency room visits		
	Other health conditions: (e.g., asthma, allergies, meningitis, heart problems, diabetes, epilepsy, cerebral palsy, spina bifida, genetic disorders, attention deficit/hyperactivity disorder, cleft palate or other)? Explain:		

SCHOOL HISTORY
Previous schools attended including preschool and kindergarten:

DATE	SCHOOL	DISTRICT	CITY/STATE	GRADE

YES	NO	(If yes, please specify)
		Did the child attend preschool? If yes, name/location:
		Was the child ever retained? If yes, what grade:
		Did the child ever miss school frequently during the same year or for an extended period of time? If yes, explain
		Was the child ever evaluated for special education before? If yes, explain:
		Did the child ever receive speech or language therapy services? If yes, explain:
		Have other children in the family had difficulty in school or received special education services?
		Did either parent have difficulty in school? If yes, explain:

Circle highest grade Mother completed in school:	6	7	8	9	10	11	12		College:	1	2	3	4
Circle highest grade Father completed in school:	6	7	8	9	10	11	12		College:	1	2	3	4

How do you feel your child gets along in school?

What do you feel are the child's major concerns in school?

Are there any of the following behaviors often descriptive of your child?

- ❑ difficulty staying in seat
- ❑ blurts out answers to questions
- ❑ difficulty sustaining attention
- ❑ difficulty following instructions
- ❑ changes from one activity to another
- ❑ easily distracted
- ❑ loses things
- ❑ talks incessantly
- ❑ difficulty waiting turn
- ❑ difficulty playing quietly
- ❑ fidgets
- ❑ interrupts
- ❑ does not listen

Are any of the following behaviors often descriptive of your child?

- ❑ loses temper
- ❑ easily annoyed
- ❑ swears or uses obscene language
- ❑ argues with adults
- ❑ angry or resentful
- ❑ blames others for own mistakes
- ❑ defies or refuses
- ❑ deliberately annoys others

Are any of the following descriptive of your child?

- ❑ steals
- ❑ fire setting
- ❑ truancy
- ❑ runs away
- ❑ lies
- ❑ drug or alcohol use
- ❑ initiates physical fights
- ❑ destructs others' property
- ❑ cruel to animals

Are any of the following behaviors often descriptive of your child?

- ❑ depressed or irritable
- ❑ sleeping difficulties
- ❑ feels worthless or guilty
- ❑ little pleasure in activities
- ❑ fatigue or loss of energy
- ❑ suicidal thoughts or attempts
- ❑ little appetite
- ❑ lethargic
- ❑ difficulty concentrating

Please check the service agencies who have had contact with your child:

❑ Department of Human Services ❑ Kid's Center ❑ Day/Residential Treatment Programs	❑ Juvenile Justice Department ❑ Mental Health/Human Services	❑ Early Childhood Special Education ❑ CDRC &/or Shriner's Hospital

Other:
Please explain:
Is there any information in this questionnaire that you would not want to appear in a written report to the school?
Other comments: