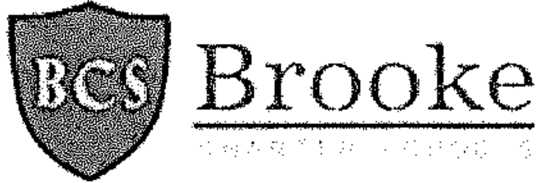

STUDENT HISTORY FORM

This student history form will help our evaluation team fully understand your child's profile. Please fill it out the best that you can. If any portions make you feel uncomfortable feel free to skip those sections.

Name of Child: ________________________ **Today's Date:** _____________

Child's Date of Birth: ______________ **Age:** ___________

Person completing this: ______________________ **Relationship to child:** ____________

What does your child enjoy and/or do well? What do you enjoy most about your child?

SOCIAL & FAMILY HISTORY

A. Language Information

Does your child have a history of exposure to a language other than English? ❑ Yes ❑ No

If answer is no, skip to section **B.**

If a language other than English is used at home, please list the country of origin:

____

What language(s) does your child get exposed to (hear, speak) in the following situations:

TV/Music:___________________________ In the community: _____________________

Neighbors:___________________________

Overall, what language do you feel your child **understands** best? ____________________

Overall, what language do you feel your child **speaks** best? _______________________

Overall, what percentage of the time do you feel your child is exposed to each or his/her languages? (for example, 80% Spanish, 20% English)? ______________________

B. Family Information

Where was your child born? ____

Please list the places your child has lived. ______________________________

Please provide the following information about all the people who live with the student and the language(s) they use when interacting with the student:

Name and Age	Relation to Child	Level of Education or current age:	Language(s) used (other than English, may be more than one):
Example: John	*Brother*	*3 yrs*	*Spanish + English*

Does any family member have: Services for being born early.

Learning Disability	❑	Speech/language problems	❑
Communication disorder	❑	Stuttering	❑
Hearing difficulties	❑	Mental Illness	❑
Attention/hyperactivity	❑	Other____________________	❑

EDUCATIONAL HISTORY

Does your child have any prior or current history of attending daycare, preschool, or school? x❑ Yes ❑ No
If so, please specify the following:

Date or Date Range	Name/Location, Schedule (e.g. – half day, full day), Grades attended (if applicable), & Language(s) of Instruction
Example: 2007-2008	*Jump Start Preschool/East Boston - Full day - English*

Were any learning/behavioral concerns noted? ❑ Yes ❑ No If Yes, please explain:

PREGNANCY & BIRTH HISTORY

Where there any complications during pregnancy or birth? ❑ Yes ❑ No If Yes, please explain:

Birth: ❑ Caesarian/C-Section ❑ Natural
Term: ❑ Full ❑ Pre-mature: born at ______ weeks of gestation
Length of hospital stay after birth: ________

DEVELOPMENTAL MILESTONES

At what age did your child sit up? ❑ 3-7 mos. ❑ 8-10 mos. ❑ I don't remember

At what age did your child crawl? ❑ 6-12 mos. ❑ 13-18 mos. ❑ Over 18 mos. ❑ I don't remember

What age did your child walk? ❑ 8-10 mos. ❑ 11-14 mos. ❑ 15-18 mos. ❑ 19-24 mos. ❑ 24 mos. or older

❑ I don't remember

At what age did your child speak single words (other than mama or dada)? _____

At what age did your child string two or more words together? _____

At what age was your child toilet trained? _____

History of: Early Intervention Services ❑ Yes ❑ No Speech-Language Therapy ❑ Yes ❑ No
Occupational Therapy ❑ Yes ❑ No Physical Therapy ❑ Yes ❑ No Counseling or ABA ❑ Yes ❑ No

If yes to any of the above questions, please explain:

CURRENT HEALTH STATUS:

Has your child had any chronic health problems (e.g., asthma, diabetes, heart condition)?
❑ Yes ❑ No If Yes, please specify type, when diagnosed, and current status:

Is your child currently taking any medication? ❑ Yes ❑ No
Yes, if so please specify type, dosage, and reason:

Do you have any health concerns for your child? ❑ Yes ❑ No

Yes, if so please explain:

Date of last vision screening: __________ location: ____________________ Pass/Fail (circle one)
Date of last hearing screening: __________ location: ____________________ Pass/Fail (circle one)

Does your child wear glasses or hearing aids? ❑ Yes ❑ No
Please specify: ______________________________
Do you have any concerns about your child's vision? ❑ Yes ❑ No
Please explain: __________________________
Do you have any concerns about your child's hearing? ❑ Yes ❑ No
Please explain:__________________________
Has your child had ear infections? ❑ Yes ❑ No If so, how many? ____________
Has your child had ear tubes? ❑ Yes ❑ No
Please explain: ____________________________________

Has your child had any surgeries? ❑ No ❑ Yes , please specify the type of surgery and when:

Has your child ever been hospitalized? ❑ Yes ❑ No If Yes , please detail:

CURRENT SKILLS:

❑ cooperative ❑ restless ❑ plays with younger children ❑ interrupts others often ❑ takes turns with others
❑ attentive ❑ poor eye contact ❑ difficulty negotiating/solving problems with peers
❑ willing to try new activities ❑ easily distracted/short attention
❑ plays alone for reasonable length of time ❑ destructive/aggressive ❑ separation difficulties ❑ withdrawn
❑ easily frustrated/impulsive ❑ inappropriate behavior ❑ stubborn ❑ self-abusive behavior

PARENT/CAREGIVER CONCERNS:

What are your primary concerns for your child at school?

What are your primary concerns for your child at home?