NEISEC Preschool Social and Developmental Record

(To be completed by parent/guardian)

Note: Completion of a social and developmental history is a required component of educational evaluations. A summary or copy of this form will be included as part of the evaluation.

Person completing this form:______________________ Date: __________________ Revision Date: _________

Family Information:

Child's Name: ____________________________ Sex: _______ Date of Birth: _____/_____/_____ Age: ______

Address:_________________________________ City: _______________________ Zip Code: ______________

Home phone: ____________________________ Email address: _______________________________________

Father's Name:_______________________________________ Age: ______

Education: _______________________________________ Occupation: _____________________________

Marital Status: ○Married ○Single ○Divorced ○Separated ○Deceased

Mother's Name: ______________________________________ Age: ______

Education: _______________________________________ Occupation: _____________________________

Marital Status ○Married ○Single ○Divorced ○Separated ○Deceased

Child lives with: ○Mother ○Father ○Both ○Other: _________________________(include address above)

Age at which child came into home if adopted or foster child: ___________________________

What is the native language of the child? ____________________

What language(s) is spoken most often by the child? _______________________________________

What language(s) is spoken by the child in the home? ______________________________________

Sisters/Brothers (*in order of birth*)	Age	Sex	Grade	At Home?
__________________________________	______	______	______	○Yes ○No
__________________________________	______	______	______	○Yes ○No
__________________________________	______	______	______	○Yes ○No
__________________________________	______	______	______	○Yes ○No
__________________________________	______	______	______	○Yes ○No
__________________________________	______	______	______	○Yes ○No

Problems/Complications during pregnancy:

☐ weakness ☐ toxemia ☐ bleeding ☐ placenta previa ☐ RH factor ☐ high blood pressure ☐ medication

☐ other: ____

Problems/Complications during delivery:

☐ premature: born at __ wks ☐ caesarian section ☐ forceps used ☐ suction used ☐ unusually long labor

☐ oxygen loss to baby ☐ low birth weight ☐ cord around neck ☐ breech birth

☐ other: ____

Developmental/Medical Information:

Birth weight: _______ pounds _____ ounces

At what age did your child do the following?
sat alone _____ crawled ____ stood alone ____ walked alone ____ toilet trained ____ dressed self ____

Date of last vision check: _____ Results: _____
Are you concerned about your child's vision? ○ Yes ○ No If yes, why? _____

Date of last hearing check: _____ Results: _____
Are you concerns about your child's hearing? ○ Yes ○ No If yes, why? _____

Does your child have a history of any of the following: ☐ ear infections ☐ impacted wax in ear ☐ PE tubes in ears (date of insertion:_____) ☐ asthma ☐ allergies ☐ chronic colds ☐ high fevers ☐ seizures ☐ tonsils and adenoids removed ☐ swallowing or chewing problems

Does your child have any medical conditions such as seizures, diabetes, ADHD, physical disabilities? ○ Yes ○ No
If so, please describe: _____

Does your child have any food allergies? ○ Yes ○ No
If yes, please list:_____

Has your child suffered from prolonged or serious illness, surgery, or serious accident/injury? ○ Yes ○ No
If so, please describe: _____

List any medications your child takes on a regular basis. Please specify type of medication what it is prescribed for, and any side effects:

Medication	What for	Side Effects

Are your child's immunizations up-to-date? ○ Yes ○ No

Family physician: _____ Phone number: _____
Other doctors?_____ Phone number: _____
_____ Phone number: _____

Communication/Oral Motor Skills:
What best describes your child's speech: ○ nonverbal ○ single words ○ two-word combinations ○ short phrases ○ sentences (3-5 words) ○ long sentences (6+ words)

Is your child's speech: ○ clear ○ unclear ○ able to be understood only by family
Does your child understand simple directions? ○ Yes ○ No

Does your child follow simple directions? ○ Yes ○ No

Comments: _____
Does your child have difficulty with oral motor skills (sucking/chewing/eating skills, difficulty using tongue/mouth, drooling, etc.)? ○ Yes ○ No
If yes, please explain:

Play Skills:
What are your child's favorite games, toys, or activities? _____
Please describe your child's behavior when with children the same age:

Does your child play make-believe? ○ Yes ○ No
If yes, please describe play:

Are you concerned about your child's play behavior? ○ Yes ○ No
If yes, please explain:

Are you concerns about your child's social skills? ○ Yes ○ No
If yes, please explain:

Behavior:
What do you believe are your child's strengths?_____

Please check any of the following which apply to your child:
☐ withdraws/avoids others ☐ head banging ☐ easily frustrated ☐ frequent physical complaints ☐ unusual fears
☐ overly active *for age* ☐ eats non-food items ☐ does not respond to name ☐ short attention span *for age*
☐ does not sleep well ☐ resists change in routine ☐ temper tantrums ☐ overly aggressive *for age* ☐ shyness
☐ unusual mannerisms (rocking, flapping, etc.) explain:_____
Are there any home circumstances that may be influencing your child's behavior and/or learning (i.e. marital problems, conflicts, illness of family members)?

Other Pertinent Information:
What individuals or agencies have worked with your family and what was done? ☐ children's hospital
☐ mental health facility ☐ welfare department ☐ Other: _____

What was done? _____

Has/does your child receive services paid for through your insurance company or Medicaid? ○ Yes ○ No
If yes, please list: _____

Please list any academic problems, physical conditions, or mental health concerns that are present in your family:

Does your child seem to learn slowly? ○ Yes ○ No

Sensory:

Is your child bothered by getting messy?	○ Yes	○ No	○ Not Sure
Is your child bothered by clothing textures or clothing tags?	○ Yes	○ No	○ Not Sure
Is your child bothered by loud or unexpected sounds?	○ Yes	○ No	○ Not Sure
Does your child eat a wide variety of foods?	○ Yes	○ No	○ Not Sure
Do any smells bother your child?	○ Yes	○ No	○ Not Sure
Is your child overly active?	○ Yes	○ No	○ Not Sure

Fine Motor:

Does your child stack blocks? ○ Yes ○ No How many? _____

Does your child scribble on a picture or paper? ○ Yes ○ No ○ Not Sure

Does your child copy vertical and horizontal lines? ○ Yes ○ No ○ Not Sure

Does your child snip paper with scissors? ○ Yes ○ No ○ Not Sure

Can your child unscrew the lid of a jar? ○ Yes ○ No ○ Not Sure

Can your child work a puzzle? ○ Yes ○ No ○ Not Sure Number of pieces

Does your child use primarily one hand when eating, coloring, and throwing, or do they switch hands frequently?
○ Right ○ Left ○ Switch

When your child holds toys, crayons, or utensils, do they use: ○ finger tips ○ whole hand ○ both

Self-help:

Does your child drink from an open cup? ○ Yes ○ No ○ Not Sure

Does your child use a spoon at meals? ○ Yes ○ No ○ Not Sure

Can your child undress self? ○ Yes ○ No ○ Not Sure

Can your child put on clothes? ○ Yes ○ No ○ Not Sure

Can your child put on shoes? ○ Yes ○ No ○ Not Sure

Can your child pull pants up/down for toileting? ○ Yes ○ No ○ Not Sure

Can your child wash own hands, front and back, with soap? ○ Yes ○ No ○ Not Sure

Gross Motor:

Can your child jump forward with both feet? ○ Yes ○ No ○ Not Sure

Can your child kick a ball? ○ Yes ○ No ○ Not Sure

Can your child walk up and down stairs with a handrail? ○ Yes ○ No ○ Not Sure

Can your child walk across a low balance beam? ○ Yes ○ No ○ Not Sure

Can your child pedal a tricycle? ○ Yes ○ No ○ Not Sure

Can your child throw a small ball forward? ○ Yes ○ No ○ Not Sure

Can your child run without difficulty? ○ Yes ○ No ○ Not Sure

Can your child safely access outdoor playground equipment? ○ Yes ○ No ○ Not Sure