Walla Walla Public Schools Health, Developmental & Social History – CONFIDENTIAL (revised 6/2014)

Date: ___________________ School: ____

Student's Name:	Birthdate: Birthplace:	Age	Sex: ___Male ___ Female
Parent Name(s):	Primary Address:	Parent Primary Phone #:	
Mother or Parent 1 Occupation: Mother or Parent 1 Highest Level of Education:	Place of Employment:	Work Phone #	
Father or Parent 2 Occupation: Father or Parent 2 Highest Level of Education:	Place of Employment:	Work Phone #	
Student lives primarily with ___Both parents ___Mother/Parent 1 ___Father/Parent 2	Number of children in household, INCLUDING THIS CHILD: _____ Child's birth order: ___1st ___2nd ___3rd ___4th ___5th ___6th		

Who resides in the primary household with this child, including ALL ADULT AND CHILD names, ages, and relationship to the child?

Name	Age	Relationship to the child

Is your child of Hispanic or Latino/a origin? Please check all that apply.
◯ NOT Hispanic/Latino/a ◯Mexican/Mexican American/Chicano ◯Cuban ◯Central American ◯Dominican ◯Spaniard ◯South American ◯ Latin American ◯Puerto Rican ◯Other Hispanic/Latino/a

What race(s) do you consider your child? Please check all that apply.
◯African American/Black ◯White ◯American Indian/Alaska Native ◯Asian American ◯Pacific Islander ◯Something not listed here: _________________

Maternal and Infant History

Mother's age at pregnancy______	Illness during pregnancy? ___No ___ Yes (please specify):		
Medications taken during pregnancy (please specify):	Duration of pregnancy: _________ weeks	Duration of labor: ______ hours Any complications? ___No ___ Yes (please specify):	
How healthy was the child as a newborn? ___Very Healthy ___Healthy ___Unhealthy ___Very Unhealthy	Home from hospital with mother? ___No ___Yes	Birth weight: ___lbs. ___oz.	
Age of newborn at discharge ___________	1st month complications? ___No ___Yes (please specify):		

Child's Developmental/Early History

Please state at what age the following things happened for your child: Talk (2 or more words) ___months; Sat up without help ___months; Stood without help ___months; Walked ___months;
Toilet training (bladder) ___months; Toilet training (bowel) ___months (Difficulty? ___No ___Yes)

Pre-Kindergarten Language and Learning Experiences

Please indicate with an "X" whether and how long your child participated in each of the following pre-kindergarten early learning experiences:	Never	Less than a year	1 year	2 years	3 years	4 years	5 years
Child care with a relative (other than occasional babysitting)							
Private Preschool (please name:_______________________________________)							
Head Start							
Early Head Start							
Something else not listed here (please name:__________________________)							

If your child participated in any of these kinds of early learning experiences, did he or she ever have any challenges or problems?
___No ___Yes (If yes, please explain):

What language did the child learn first? _________________ What is the primary language of the parent(s)? ___________________
What language is/was used at home by the child before age 5? ______________________
What language is/was used at home by the parents and/or caregivers before the child was 5 years old? _______________________
In your opinion, which language does the child understand best? ______________________
Does your child have any chores? ___No ___Yes (please list):

Please circle any words or phrases that may describe your child: Affectionate Shy Friendly Happy Withdrawn Inactive

Curious Hyperactive Impulsive or explosive behavior Cries easily Aggressive Prefers to be alone Easily frustrated

Smart Fearful Careful Easily angered Creative Impatient Talkative

Physical and Mental Health

Date of last physical exam: / / 20____ Physician: Location:
Is the child taking any medications? ___No ___Yes (if yes, please answer these questions on condition and medication): Condition:___________________________ Medication name: __________________ Dosage: ________ Frequency: ____________
Did this child suck his or her thumb? ___No ___Yes Has the child ever had any severe injuries, including head trauma? ___No ___Yes (please describe): Has the child ever had any surgeries? ___No ___Yes (please describe): Has the child ever had any severe illness? ___No ___Yes (please describe): Has the child ever been hospitalized for a medical condition? ___No ___Yes (please describe): Has the child been seen by a __psychologist, __psychiatrist, __counselor? (If yes to any of these, please specify dates and reason): Has this child been diagnosed with a congenital disease or syndrome? ___No ___Yes (if yes, please specify date and diagnosis):

Please indicate with "X" these past and present health conditions for your child.	This WAS true for this child, but is NOT A CONCERN NOW. ↓	This is TRUE for this child NOW. ↓
Allergy (foods/environment)		
Anemia		
Appetite problems		
Attention problems		
Bedwetting		
Colds – frequent		
Color blindness		
Concussion		
Diabetes		
Ear infections (tubes? ___No ___Yes)		
Eye problems (glasses? ___No ___Yes)		
Fevers over 104°		
Genetic syndrome or disorder		
Headaches		
Hearing loss (hearing aids? ___No ___Yes)		
Hyperactivity		
Meningitis		
Seizures		
Sleep problems (average hours/night _____)		
Speech problems		
Stomach aches		
Other:________________		

Please indicate with "X" whether any family members have had these conditions.	Parent	Sibling	Grandparent	Aunt or Uncle
ADHD				
Anxiety				
Autism, including Asperger's				
Depression				
Developmental problems				
Genetic syndrome or disorder				
Learning disability				
Mental illness				
Neurological disorder				
Post-traumatic stress disorder				

Has the child been seen by an eye doctor? ___No ___Yes (if yes, what is the name of the eye doctor?):

Has the child been seen by a speech/hearing specialist? ___No ___Yes (if yes, what is the name of the specialist?):

How often does the child eat high sugar foods? __Never __Seldom __Sometimes __Frequently
What foods does the child eat frequently?

Social and Environmental Factors (*Understanding these factors may help us support your child's growth and learning)*

Please rate how much each of these statements is true for your child and family.	Completely or Always	Very much or Frequently	Somewhat or Sometimes	Not much or Infrequently	Not at all or Never	Does not apply
This child's parents/caregivers agree about parenting techniques.						
There are family problems that may affect this child's behavior.						
This child has a good relationship with his or her mother/parent 1.						
This child has a good relationship with his or her father/parent 2.						
This child has a good relationship with his or her siblings.						
I have people who encourage me when I find parenting difficult.						
I have people I can talk to if I have questions about raising children.						
This child has seen adults hit, push, or kick others.						
This child has seen adults yell at others.						
Our basic needs (food/shelter/clothing) have been met in the past.						
Our basic needs (food/shelter/clothing) are being met now.						
This child has experienced a death in his or her immediate family.						
This child has experienced divorce within our immediate family.						
This child has moved in the last two years.						
My family works with local agencies to help us meet basic needs.						