East Central Special Education

16 South 8th St

New Rockford, ND 58356

Social Medical History

Child’s Name:   

 (Last) (First) (Middle)

Date of Birth: Click here to enter a date. Age: Grade: 

Home School: 

Servicing School: 

Name and Age of Brothers and Sisters:



Parents: Mother:  Father: 

Please Check: Biological[ ]  Adoptive[ ]  Foster[ ]  Guardian[ ]  Other[ ]

 

Address City, State, Zip

Telephone: Home:  Work: 

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Signature of Person Completing Form Date

**BIRTH HISTORY**

Age of Father at time of child’s birth: 

Age of Mother at time of child’s birth: 

Child’s birth weight: 

Describe any unusual illnesses or conditions during Mother’s pregnancy:



Describe any unusual labor problems or difficulties:



Describe any problems or difficulties baby had at delivery:



**GROWTH AND DEVELOPMENT**

Please rate your child’s motor development:

(1)[ ]  (2)[ ]  (3)[ ]  (4)[ ]  (5)[ ]

 (below average) (average) (above average)

Please rate your child’s growth:

(1)[ ]  (2)[ ]  (3)[ ]  (4)[ ]  (5)[ ]

 (below average) (average) (above average)

Please describe any problems you feel your child has with coordination:



Please describe any history of speech/language problems in your family:



Please describe your child’s ability to express his/her thoughts:



Please describe your child’s attention: (ex. Following directions, listening to stories, watching television:



**HEARING**

Does your child respond to sounds/voices: Yes[ ]  No[ ]

Does your child understand what is said to him/her: Yes[ ]  No[ ]

Does your child often ask you to repeat what you have said: Yes[ ]  No[ ]

Has your child’s hearing ever been checked: Yes[ ]  No[ ]

Please describe any history of hearing problems in the family:



**VISION**

Does your child:

 Blink frequently[ ]  Has your child’s vision ever been checked:

 Rub eyes frequently[ ]  Yes[ ]  No[ ]

 Squint[ ]  Does your child wear glasses: Yes[ ]  No[ ]

Please describe any history of vision problems in the family:



**PERSONAL CARE**

Please describe any difficulties your child has with:

Eating:



Dressing:



Bowel/Bladder Control:



**BEHAVIORAL, EDUCATION AND SOCIAL SKILLS**

List some interests of your child (hobbies, sports etc.):



How does your child respond when under stress:



Please describe any problems you feel your child has with behavior:



What age group does your child relate to most of the time:



Do you think your child has a learning problem: Yes[ ]  No[ ]

If yes, please describe:



If your child is of school age, rate your child’s performance in school:

(1)[ ]  (2)[ ]  (3)[ ]  (4)[ ]  (5)[ ]

 below average (average) (above average)

Comments:



**MEDICAL HISTORY**

Please check the items that apply to your child and add comments as you feel necessary:

 [ ] Recent physical examination

 Family physician: 

 [ ] Neurological examination

 [ ] Serious illness

 [ ] Surgery

 [ ] Long term medication

 [ ] Frequent ear infections

 [ ] Physical limitations

 [ ] Allergies

 [ ] Other

Please state any questions, comments or concerns you may have in the space below:

