East Central Center for Exceptional Children
16 South 8th St
New Rockford, ND 58356

Social Medical History

Child's Name:_____
(Last) (First) (Middle)

Date of Birth:_____ 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:_____

_____ _____
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_____

Does your child understand what is said to him/her_____

Does your child often ask you to repeat what you have said_____

Has your child's hearing ever been checked_____

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 _____

Squint _____ Does your child wear glasses____

Please describe any history of vision problems in the family:

_____

PERSONAL CARE

Please describe any difficulties your child has with:

Easting:_____

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:_____ 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 feel free to state any questions, comments or concerns you may have in the space below.