

Albany County Department for Children, Youth and Families
Comprehensive Evaluation Services
Child Information/Social History

Child's Name: _____ Birth Date: _____
Age: _____ Sex: _____ Phone: _____
Parent(s)/Guardian(s): _____
Email address: _____

I. Prenatal/Neonatal History:

- | | | | |
|----|--|--------|-------|
| 1. | Did you have any illnesses during your pregnancy..... | No | Yes |
| | If yes, explain_____ | | |
| 2. | Did you smoke cigarettes/marijuana during your pregnancy..... | No | Yes |
| 3. | Did you drink alcoholic beverages during your pregnancy..... | No | Yes |
| 4. | Did you use legal and/or illegal substances during your pregnancy | No | Yes |
| 5. | Was your child born full term..... | No | Yes |
| | If no, at approximately how many gestational weeks was your child born _____ | | |
| 6. | How much did your child weigh at birth..... | __ lbs | __ oz |
| 7. | Did he/she have trouble starting to breath..... | No | Yes |
| 8. | Did he/she have any difficulties while in the hospital..... | No | Yes |
| | If yes, explain_____ | | |
| 9. | Did he/she go home with you when you left the hospital..... | No | Yes |
| | If no, explain_____ | | |
| | If no, how long did he/she stay in the hospital..... ____ days | | |

II. Medical History:

- | | | | |
|-----|---|----|-----|
| 1. | Please list any of your child's diagnosed medical conditions_____ | | |
| 2. | Please list your child's pediatrician_____ | | |
| 3. | Please list any specialists following your child_____ | | |
| 4. | Do you have any concerns about your child's hearing..... | No | Yes |
| 5. | Do you have any concerns about your child's vision..... | No | Yes |
| 6. | Do you have any concerns about your child's dental health..... | No | Yes |
| 7. | Has your child had more than 6 colds in one year..... | No | Yes |
| 8. | Has your child had more than 3 ear infections in one year..... | No | Yes |
| | If yes, how many_____ | | |
| 9. | Does your child have frequent respiratory infections..... | No | Yes |
| 10. | Does your child have asthma..... | No | Yes |
| 11. | Does your child have any allergies | No | Yes |
| | If yes, to what_____ | | |
| 12. | Has your child had any seizures..... | No | Yes |
| | If yes, age_____ Type_____ | | |
| 13. | Has your child had high lead levels..... | No | Yes |
| | If yes, age_____ Level _____ | | |
| 14. | Is your child currently taking any medication..... | No | Yes |
| | If yes, what medication_____ Reason_____ | | |

Medical History Continued....

- | | | | |
|-----|--|------------------|-----|
| 15. | Has your child had any serious accidents..... | No | Yes |
| | If yes, explain_____ | | |
| 16. | Has your child ever had to stay overnight in the hospital..... | No | Yes |
| | If yes, reason(s)_____ | | |
| | Age(s)_____ | Hospital(s)_____ | |

III. Developmental History:

- | | | | |
|----|---|----|-----|
| 1. | Has your child ever participated in an Early Intervention or
Preschool Evaluation..... | No | Yes |
| 2. | Have they previously received/are currently receiving any services
If yes, what service(s)_____ | No | Yes |
| 3. | At what age did your child roll _____
If uncertain, did your child roll by 6 months of age..... | No | Yes |
| 4. | At what age did your child sit independently_____
If uncertain, did your child sit independently by 7 months of age... | No | Yes |
| 5. | At what age did your child crawl_____
If uncertain, did your child crawl by 10 months of age..... | No | Yes |
| 6. | At what age did your child walk alone_____ | | |
| 7. | If uncertain, did your child walk alone by 15 months of age..... | No | Yes |

IV. Speech-Language/Hearing History:

- | | | | |
|-----|--|----|-----|
| 1. | Did your child cry a lot as an infant..... | No | Yes |
| 2. | Could you tell the difference between the cries..... | No | Yes |
| 3. | Did your child babble (e.g., ba-ba-ba) by 6 months of age..... | No | Yes |
| 4. | Did your child say 3 or more words by 12 months of age..... | No | Yes |
| 5. | Did your child say 5-10 words by 24 months of age..... | No | Yes |
| 6. | Did your child combine 2 words by 30 months of age..... | No | Yes |
| 7. | Did your child combine 3 words by 36 months of age..... | No | Yes |
| 8. | Does your child speak in an unusually loud voice..... | No | Yes |
| 9. | Do familiar adults understand your child..... | No | Yes |
| 10. | Do unfamiliar adults understand your child..... | No | Yes |

V. Feeding History:

- | | | | |
|----|--|----|-----|
| 1. | Did your child have any difficulty sucking as an infant..... | No | Yes |
| 2. | Does your child have any difficulty swallowing..... | No | Yes |
| 3. | Does your child have any difficulty chewing..... | No | Yes |
| 4. | Does your child drool..... | No | Yes |
| 5. | Does your child eat a variety of foods and textures..... | No | Yes |
| 6. | Would you describe your child to be a picky eater..... | No | Yes |
| 7. | Does your child use a pacifier..... | No | Yes |

VI. Child Description:

- | | | | |
|----|--|----|-----|
| 1. | Does your child appear frustrated when he/she is unable to express
his/her wants/needs..... | No | Yes |
| | If yes, how is this frustration displayed_____ | | |
| 2. | Does your child have any nervous habits..... | No | Yes |
| | If yes, explain_____ | | |

Child Description Continued....

- | | | | |
|----|---|----|-----|
| 3. | Does your child have excessive temper tantrums..... | No | Yes |
| | If yes, describe_____ | | |
| 4. | Does your child sleep through the night..... | No | Yes |
| 5. | Is your child overactive..... | No | Yes |
| 6. | Is your child's behavior difficult to manage..... | No | Yes |
| 7. | Is there anything else you would like to share about your child | | |
| | _____ | | |
| | _____ | | |

VII. Toileting Skills:

- | | | | |
|----|--|----|-----|
| 1. | Does your child wear a diaper during the day..... | No | Yes |
| 2. | Does your child wear a diaper through the night..... | No | Yes |
| 3. | Does your child use the toilet independently..... | No | Yes |

VIII. Family-Social History:

- | | | | |
|----|--|----|-----|
| 1. | Do any members of your child's immediate family (brothers, sisters, parents, grandparents, aunts, uncles) have speech, language or hearing difficulties..... | No | Yes |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| 2. | Do any members of your child's immediate family have learning difficulties (e.g., ADHD, autism, dyslexia, etc.)..... | No | Yes |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| 3. | Do any members of your child's immediate family suffer from mental illness (e.g., anxiety, depression, bipolar disorder, etc.)..... | No | Yes |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| | Who:_____ Difficulty:_____ | | |
| 4. | Who resides in your home (e.g., parents, siblings, etc.) | | |
| | Name:_____ relationship:_____ age:_____ | | |
| | Name:_____ relationship:_____ age:_____ | | |
| | Name:_____ relationship:_____ age:_____ | | |
| | Name:_____ relationship:_____ age:_____ | | |
| | Name:_____ relationship:_____ age:_____ | | |
| 5. | What language(s) is spoken in the home? | | |
| | Primary:_____ | | |
| | Secondary:_____ | | |