



MOUNTAIN ROAD SCHOOL

5 Abode Road, New Lebanon, NY 12125

Tel (518) 794-8520 · Fax (518) 794-8623

www.mountainroadschool.org

SOCIAL HISTORY QUESTIONNAIRE

We appreciate you taking your time to fill out this questionnaire so we can learn more about your child. Thank you!

Date: _____

Current Information

Child's Name: _____ M/F _____

Date of Birth: _____ Age _____

Parent(s) Name (s) and relationship to child _____

Marital Status (married, separated, divorced, deaths) _____

If separated or divorced:

Who does the child live with? _____ Who has custody? _____

How often are visits with the other parent? _____

Siblings: (names, ages, relationship to child, residence)

- 1. _____ age: _____ relationship to child: _____ residence: _____
- 2. _____ age: _____ relationship to child: _____ residence: _____
- 3. _____ age: _____ relationship to child: _____ residence: _____
- 4. _____ age: _____ relationship to child: _____ residence: _____

How does your child get along with siblings? _____

Pregnancy and Prenatal/Postnatal Period:

Please describe the child's birth _____

Was the delivery _____ Normal? _____ Breech? _____ Caesarian? _____ Induced?

Developmental Milestones:

At what age did child sit up? _____ 3-6 months _____ 7-12 months _____ over 12 months _____ DK

At what age did child crawl? _____ 6-12 months _____ 13-18 months _____ over 18 months _____ DK

At what age did child walk? _____ under 1 yr. _____ 1-2 yrs. _____ 2-3 yrs. _____ DK

At what age did child speak single words (other than mama or dada)? _____ 9-13 months

_____ 14-18 months _____ 19-24 months _____ 25-36 months _____ 37-48 months _____ DK

At what age did child string two or more words together? 9-13 months 14-18 months
 19-24 months 25-36 months 37-48 months DK

At what age was child toilet trained? under 1 yr. 1-2 yrs. 2-3 yrs. 3-4 yrs. DK

Bed-wetting or bed soiling after toilet training? yes no

Medical reasons for bed-wetting, soiling _____

Are there, or have there had been, any problems in the following areas? If yes please describe.

Difficulty walking	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Unclear speech	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Eating problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Underweight	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Overweight	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Sleep problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Temper tantrums	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Excessive crying	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Failure to thrive	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Sleeping too little	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Difficulty learning to ride a bike	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Difficulty learning to throw or catch	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____

Medical History:

Any medical conditions/chronic illnesses we should know of:

Has your child had any accidents resulting in serious injury? If yes, please describe _____

Is your child on any medications? If so, please list medication, purpose and duration of use:

Allergies:

To medicines yes no describe _____

To foods yes no describe _____

Other yes no describe _____

How would you describe your child's health? Good Fair Poor

How is your child's hearing? Good Fair Poor

Does your child wear a hearing aid? yes no

How is your child's vision? Good Fair Poor

Does your child wear glasses? yes no

Does your child wear contact lenses? yes no

How is your child's fine motor coordination? Good Fair Poor

How is your child's gross motor coordination? Good Fair Poor

How is your child's speech articulation? Good Fair Poor

Neurological:

Has your child exhibited any of the following? If yes, please describe:

Seizures	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Speech defects	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Bangs head	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Has tics/twitches	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Rocks back&forth	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____

Previous Treatment:

Has your child ever had psychological counseling or therapy? yes no

If yes, when? (dates/duration of counseling) _____

What type of counseling? (individual, group, family, residential treatment) _____

Reason for counseling? _____

Counselor's name _____

Address _____

Telephone _____

Social History:

Child gets along with peers Better than average Average Worse than average

Child gets along with adults Better than average Average Worse than average

Please describe: _____

Recreation:

What outdoor activities does your child enjoy? _____

What indoor activities does your child enjoy? _____

How much exposure to nature has your child experienced? _____

Behavior:

Do you have any current behavioral concerns for your child? yes no

If yes, please describe: _____

When did the behavior(s) first begin? _____

What strategies have been implemented to address these problems? (check all that apply)

Verbal reprimands Removal of privileges Rewards

Time out Removal of possessions Giving in to child

Avoidance of child Physical punishment Ignoring it

To what extent are you and your spouse consistent with respect to disciplinary strategies?

Most of the time Some of the time None of the time

Have any of the following stress events occurred within the past 12 months?

Parents divorced or separated Family accident or illness

Death in family Parent changed job

Changed schools Family moved

Family financial problems Other: _____

Education History:

Has your child ever received any of the following services, and if so, for how long?

<input type="checkbox"/> Academic Intervention Services (AIS)	Duration: _____
<input type="checkbox"/> Speech/Language Therapy	Duration: _____
<input type="checkbox"/> Occupational Therapy (OT)	Duration: _____
<input type="checkbox"/> Physical Therapy (PT)	Duration: _____
<input type="checkbox"/> Counseling	Duration: _____
<input type="checkbox"/> Resource room	Duration: _____

What are your child's strengths?

What are areas of difficulty?

Describe the educational environment you are seeking for your child:

Has your child ever been:

<input type="checkbox"/> Suspended from school	Number of suspensions: _____
<input type="checkbox"/> Expelled from school	Number of expulsions: _____
<input type="checkbox"/> Retained in grade	Number of retentions: _____

Additional Comments:

Thank you for helping us understand your child better!