



# MOUNTAIN ROAD SCHOOL

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## 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 \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Unclear speech \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Eating problems \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Underweight \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Overweight \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Sleep problems \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Temper tantrums \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Excessive crying \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Failure to thrive \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Sleeping too little \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Difficulty learning to ride a bike \_\_\_ yes \_\_\_ no \_\_\_\_\_  
Difficulty learning to throw or catch \_\_\_ yes \_\_\_ 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  yes  no \_\_\_\_\_
- Speech defects  yes  no \_\_\_\_\_
- Bangs head  yes  no \_\_\_\_\_
- Has tics/twitches  yes  no \_\_\_\_\_
- Rocks back&forth  yes  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:

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Thank you for helping us understand your child better!