



Have any family members had learning, speech, or hearing problems?  Yes  No

If yes, please explain

The primary language spoken at home is:

Student's

Parent's

Does the student have any sleep difficulties?

What activities do the family do together (for example, watching TV, camping, play sports, etc.)?

What does the student do when not in school?

Have there been any important changes within the family during the last three years (for example, job changes, moves, births, deaths, divorce, etc.)?

**Behaviors**

Please describe the student's behavior at home. (For example, is he/she generally well-behaved? Have there been any recent changes in behavior? How does he/she get along with other family members, neighbors, and playmates?, etc.)

Does the student exhibit behaviors that you feel are affecting his/her progress at school? If yes, please check the appropriate behaviors.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Often interrupts adults/others | <input type="checkbox"/> Threatens to run away from home | <input type="checkbox"/> Uses bad language             |
| <input type="checkbox"/> Is uncooperative               | <input type="checkbox"/> Intentionally breaks things     | <input type="checkbox"/> Is cruel to animals           |
| <input type="checkbox"/> Frequently argues or disagrees | <input type="checkbox"/> Has been involved in vandalism  | <input type="checkbox"/> Smokes, drinks, or does drugs |
| <input type="checkbox"/> Is disobedient                 | <input type="checkbox"/> Often brags or boasts           | <input type="checkbox"/> Has a bad reputation          |
| <input type="checkbox"/> Refuses to listen              | <input type="checkbox"/> Is a show-off                   | <input type="checkbox"/> Is in trouble with the police |
| <input type="checkbox"/> Is stubborn                    | <input type="checkbox"/> Threatens to hurt others        | <input type="checkbox"/> Is defiant                    |
| <input type="checkbox"/> Is resentful                   | <input type="checkbox"/> Frequently sulks or pouts       | <input type="checkbox"/> Is irresponsible              |
| <input type="checkbox"/> Is secretive                   | <input type="checkbox"/> Is demanding                    | <input type="checkbox"/> Doesn't complete chores       |
| <input type="checkbox"/> Is too aggressive              | <input type="checkbox"/> Does not respond to punishment  | <input type="checkbox"/> Manipulates others            |
| <input type="checkbox"/> Has a bad temper               | <input type="checkbox"/> Plays with matches or fire      | <input type="checkbox"/> Has to have their own way     |

What methods of discipline are used with the student at home? For example, spanking, extra chores, time out, etc.

What is your child's reaction to discipline?

**School Information**

Please provide the following information for all schools attended by your child

School Name	Address	City	State	Zip Code	Years attended

Has your child previously been referred to or served by special education?

Yes  No

If yes, list school(s), including the years served, that your child received services.

Has your child previously been seen by a psychologist or psychiatrist?

Yes  No

Has your child previously been referred to or received speech therapy?

Yes  No

If yes, list school(s), including the years served, that your child received services.

Please check if your child has attended one of the following state supported programs:

State School for the Mentally Retarded

State Mental Hospital

Regional Day School for the Deaf

Early Childhood Intervention Program

Other

For how long?

Has your child repeated a grade in school?

Yes  No

If yes, what grade(s)?

What are some of your child's strengths?

Do you feel your child is experiencing problems at school?  Yes  No

What kinds of problems?

When were you first aware of a problem (s)?

What do you think is causing the problem (s)?

Has your child mentioned problems with school?

How does he/she feel about the problem (s)?

Briefly discuss any other important information about your child.

### **Health Information**

Yes  No Were there any problems before, during or immediately after birth (physical or emotional)?

If yes, please explain

Compared to other children in the family, was this child's development:  Slower  About the same  Faster  N/A

Yes  No Has your child had a history of ear infections?

Yes  No Does your child currently have tubes in his/her ears?

Yes  No Has he/she previously had tubes?

Yes  No Does your child appear to have any other physical health problems, including allergies? Please explain:

Yes  No Is your child under the care of a physician for a medical/psychological problem? If yes, please explain and list the physician's name and phone number.

Yes

No

Is your child now taking any medication? If yes, please explain:

Yes

No

Do you know of any side effects the medicine might have? If yes, please explain:

Yes

No

Has your child ever taken medicine for a long period of time? If yes, please explain:

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person completing this section, if information  
was obtained through parent interview

\_\_\_\_\_  
Position

\_\_\_\_\_  
Date