



**Special Services Cooperative
of Jefferson County**

General Information

Date: _____

Family History					
Full Legal Name Last Name		First Name	Middle	Nickname/Goes By	Date of Birth
Student's SSN:				Age	<input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address No. Street City State Zip				Telephone Number () -	
Marital Status of Parents:			Primary Language spoken in home:		
Mothers Name:			Fathers Name:		
Father's Occupation:			Work Ph. () - ext. Cell Ph. () -		
Mother's Occupation:			Work Ph. () - ext. Cell Ph. () -		
Legal Guardian (If different than above):					
Legal Guardians Address No. Street City State Zip				Telephone Number () -	
Members of Household	Relationship to Student	Age	Sex		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
Family Crisis or Major Changes in Family Constellation:					
Agencies involved with: <input type="checkbox"/> First Steps: <input type="checkbox"/> Regional Center <input type="checkbox"/> Parents As Teachers <input type="checkbox"/> Head Start <input type="checkbox"/> Other Agencies Case Workers Name: _____					

Birth History

Length of pregnancy: Full Term Premature Late

Number of days child was in the hospital after birth?

Describe the child's health immediately after birth:

Developmental History

Approximate age child was able to do the following behaviors:

Sit alone:

Crawl:

Stand Alone:

Walk Alone:

Say first words:

Use Sentences:

Toilet Trained:

Discuss any above behaviors (if desired):

Medical History

Are there any relevant medical findings/diagnosis?

Major Illnesses? (Chicken pox, mumps, polio, etc.)

History of ear infections? Yes (specify below) No

_____ Number of ear infections in the past year

Tubes inserted? Yes No When?

Seizures or Convulsions? Yes No

Medicated? Yes No

Briefly describe seizures.

Extended High Fevers?

Length of Time:

Other serious conditions/surgeries/hospitalizations?

Does your child wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what?
Does your child wear hearing aides? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what? <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both Ears
Is your child currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list the name of the medication(s), dosage, & times taken below?	
Allergies during infancy?	Allergies at present?
List doctors, clinics, hospitals when applicable:	
Current Functioning	
Difficulty with eating certain foods?	
Difficulty with sleeping?	
Unusual behaviors/habits (sucking thumb, chewing fingernails, grinding teeth, etc.)?	
Relations with peers?	
Plays with peers/siblings?	
<p>General behaviors shown at home:</p> <input type="checkbox"/> High Activity Level <input type="checkbox"/> Short Attention Span <input type="checkbox"/> Poor Self-Control <input type="checkbox"/> Low Frustration Level <input type="checkbox"/> Temper Tantrums <input type="checkbox"/> Interrupts Frequently <input type="checkbox"/> Doesn't Listen When Spoken to <input type="checkbox"/> Stubborn <input type="checkbox"/> Doesn't Learn From Experience <input type="checkbox"/> Sudden Outburst of Physical Abuse to other Children <p>Discuss any of the behaviors checked above:</p>	
How do you handle it when your child misbehaves at home?	

Parent's description of reason for referral?

Age of child when problems were first noted?

Is Special Services Cooperative the first agency contacted in regards to this problem?

Has the condition of your child progressed or regressed in the past year?

Where Does Your Child Spend Their Day

What are your childcare arrangements?

Does your child attend Preschool or Day Care? Yes No

Name of Preschool or Day Care:

What days and hours does he/she attend:

Name of public school district in which child resides?

Current Placement?

Does your child currently receive any extra help?

Has your child ever been retained?

Describe any grade level adjustments and any problems noted:

Current school situation:

What does the parent want to get out of this evaluation?