CONFIDENTIAL

School: Ilion Central School
Address: 1 Golden Bomber Drive, Ilion, NY 13357
CSE/CPSE Chairperson:______________________________
Date of Report:_____________________________________

Social History

Student's Name:___________________________________ Date of Birth:_________________________

Address:____ Telephone:_________________________

Reason for Referral:

Father's Name:_______________________________ Mother's Name:______________________

D.O.B.:____________________________________ D.O.B./Maiden Name:_________________

Address:___________________________________ Address:____________________________

Home Phone:_______________________________ Home Phone:_________________________

Employment:_______________________________ Employment:_________________________

Schooling:_________________________________ Schooling:____________________________

Name of person(s) who has legal custody of student:____

Relationship to student:____

Date custody obtained:____

Siblings	Date of Birth	School Attendance	Grade	Check if Living in the Home

Others in home	Date of Birth or Age	Relationship to Student	Employment

Child's School History:

Pre-School: Yes □ No □ Name of Pre-School:______________________________
Describe experience/adjustment to program:____
____

Elementary/Jr.-Sr. High School

Name of School	Grade	Year	Describe experience/adjustment to school year

Child's Birth History:

Pre and Post Natal:

What month did pre-natal care start? ________________________
Did mother have any complications during pregnancy? Toxemia □ Bleeding □ Infection □ Other □
Explain:____

Did mother take any medications during pregnancy? Yes □ No □
Explain:____

During pregnancy, did mother: Smoke: Yes □ No □ Use Drugs: Yes □ No □
Use Alcohol: Yes □ No □

If so, to what extent or how often/how much?____

Was child full term? Yes □ No □ Premature/overdue by how long?________wks/mos

Were there any complications during delivery? Yes □ No □
Explain:____

Child's weight at birth:____________________ Child's condition at birth:_____________________

City and State of birth:____

Child's Developmental History:

Age child walked alone:__________________
Age child began talking:__________________
Age child toilet trained:___________________

Any concerns about child's development? Yes □ No □

If yes, please explain:

Child's Health History:

Has your child ever been hospitalized? Yes ☐ No ☐ If Yes, When?______________________
Reason?____ Length of Stay?______________________

Does your child have any current health concerns? Yes ☐ No ☐
Explain:____
____

Is your child currently taking any medications? Yes ☐ No ☐
Explain:____

Are there any physical restrictions or limitations? Yes ☐ No ☐
Explain:____

Has your child ever had any of the following diseases or health concerns? (Check all that apply)

Mumps		Chicken Pox		German Measles		Measles	
Polio		Scarlet Fever		Rheumatic Fever		TB	
Diabetes		Pneumonia		Heart Condition		Asthma	
ADHD or ADD		Ear Infections		Bladder Problems		Bowel Problems	
Chronic Colds		Speech Concerns		Hearing Concerns		Vision Concerns	
High Temperatures		Allergies		Seizures		Anxiety	
Behavioral Problems		Emotional Problems		Coordination Problems		Sleeping Problems	
Eating Problems		Other					

Explain the above if necessary:____
____

Family History: Is there any history in your child's family of the following?

	Mother's Side of Family	Father's Side of Family
Diabetes		
Epilepsy		
Cardiac/Heart		
Cancer		
Mental Illness		
Retardation		
Learning Difficulties		
Alcohol/Drug Abuse		
Other		

Have there been any significant changes in the home or family routine that your child is having or has had trouble adjusting to?

☐ No
☐ Changes in family composition – ☐ births ☐ deaths ☐ separation ☐ divorce
☐ Illnesses ☐ Family Moves ☐ Other

Please explain those checked if you so choose:
____
____

Child Relationships:

Describe how your child gets along with:

Parents	
Siblings	
Peers	

Child:

Is your child demonstrating any behaviors that are a concern such as: (Check all that apply)

Fire-Setting		Hurting Pets		Withdrawn		Overly Friendly	
Lying		Hurting Siblings		Moody		Frightened	
Stealing		Hurting Parents		Overly Jealous		Sleeping	
Fantasizing		Hurting Peers		Nightmares		Eating	
In Own World		Hurting Self		Bedwetting		Other (describe below)	

Describe your child's personality (i.e. shy, friendly, etc):

Signature:____ Date:____________________

Relationship to child:________________________________

Reviewed by:_______________________________________
Title/Position:______________________________________
Date:____

(Form Revised: 06/10)