VALLEY SCHOOL DISTRICT **SPECIAL EDUCATION**
555 West Valley Rd, Yakima, WA 98902 Phone: (509) 456-8596 Fax: (509) 658-9856

Student Developmental/Health/History Assessment Form

Student name **Jason Patterson** Student # **49** Date **11/24/2008**

I. Personal and Family History:

Child's Name _____ Sex _____ Date of Birth 2/6/2002

Address 4690 Edsel Road Telephone 818-404-0831

Father's Name _____ Mother's Name _____

Brothers and Sisters (Age, Sex)

- Family Physician _____
- Family History of:

☐ Asthma	☐ Epilepsy	☐ Mental Retardation
☐ Birth Defects	☐ Hearing Problems	☐ Learning Problems
☐ Diabetes	☐ Speech/Language Problems	☐ Mental Illness

Please explain any items marked:

_____

- Recent Stressors:
  Divorce _____ Loss of Job _____ Separation _____
  Move _____ Death _____ Family Illness _____

Please explain any items marked

_____

II. Child's History:

- Complications during pregnancy (explain):
  _____ High temps. _____
- Complications at birth (explain):
  _____ Birth weight _____
  Smoked _____ Alcohol _____ Medications _____
- Age at which your child (use "N" for normal): Spoke: words _____ sentences _____
  sat up _____ crawled _____ walked _____ toilet trained _____

- Consistent problems with:

Physical	Conduct	Anxiety/Depression	Thought Process
☐ Vision	☐ High activity level	☐ Unhappiness/depressed mood	☐ Bizarre ideas
☐ Hearing	☐ Distractible	☐ Apprehension/worrying	☐ Disconnected, loose, fragmented language
☐ Speech/Language	☐ Frequent inter-personal problems	☐ Somatic complaints/illnesses	☐ Inability to express ideas
☐ Motor Development	☐ Aggressiveness	☐ General nervousness	☐ Inability to deal with abstraction, environmental changes
	☐ Impulsivity - unable delay gratification	☐ Eating	☐ Unusual social mannerisms/behaviors
	☐ Lying	☐ Nightmares	
	☐ Stealing	☐ Sleep problems/increased or decreased	
	☐ Difficulty with authority, rules, limits, laws	☐ Thumbsucking, nailbiting or other nervous habits	
		☐ Bedwetting	
		☐ Concern about physical	
		☐ Unreasonable fears	
		☐ Difficulty with attention/ concentration	
		☐ Suicidal ideations	

Please explain as needed: _____

_____

- Past Illnesses:

☐ Accidents	☐ Operations
☐ Allergies	☐ Serious head injuries
☐ Chronic ear infections	☐ Serious illness
☐ Epilepsy	☐ Seizures
☐ Bleeding disorders	☐ Diabetes
☐ High fever	☐ Other _____

Please explain any items marked _____

_____

- Is child on medication? If yes, what? _____

III. Behavioral:

- Does your child have trouble getting along with (check if yes):

☐ Children at school	☐ Other children
☐ Brothers and sisters	☐ Parents
☐ Teachers	☐ School

Comments:

_____

- Special Interests _____
- Does your child have difficulty accepting responsibilities at home? ☐ Yes ☐ No
- Most effective method of discipline: _____

IV. Educational:

- Past school experiences (include grades repeated, dates, location)

_____

- Please provide any additional comments, concerns or background information that might assist us in working with your child:

_____

Signed: _____ Date: _____