St. Gabriel School
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SOCIAL/DEVELOPMENTAL HISTORY FORM

Name of Pupil_____Date of Birth_____

Address_____History given by_____Date____

The following questionnaire is to help know your child's strengths and weaknesses so that we can better meet individual needs in kindergarten.

FAMILY - List the people living in the child's home:

Full Name	Birth date	Relationship To Child	Grade completed
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____

LANGUAGE DEVELOPMENT

Approximately when did your child say First Words_____
Sentences_____

Please check present language patterns:

_____ Clear Speech _____ Stutters
_____ Lisp _____ Specific sound substitutions
_____ Baby Talk _____ Can express ideas effectively
_____ Understands spoken words
_____ Uses single words; _____phrases; _____sentences

Are other languages spoken in the home: Yes_____; No_____
Which ones_____ How often_____

MOTOR DEVELOPMENT

Approximately what age did your child: Sit____; Crawl_____; Stand_____; Walk_____
Become toilet trained_____:
Any toilet accidents? Yes____; No____; Day_____; Night_____: How often_____

Please check present motor skills:

_____ Runs
_____ Hops
_____ Skips
_____ Balances on one foot
_____ Uses Crayons; _____Pencils; _____scissors;

_____ Climbs stairs correctly
_____ Rides tricycle or bicycle
_____ Throw and catches ball
_____ Seems well coordinated

Hand Preference: _____right; _____left; _____both

READINESS:

Please check activities your child can do.

_____ Writes Name
_____ Remembers short messages (word for word)
_____ Follows 3 part directions
Recognizes: _____ Numbers, _____ Colors, _____ Letters, _____ Words
_____ Dresses self
Shows imagination in:
_____ Story Telling
_____ Drawing
_____ Building and Making Things
_____ Play Activities
_____ Other
Attended preschool program _____ yes; _____ no;
If yes, where_____
How Often_____

_____ Has own library card

HEALTH (check all appropriate items)

_____ Is generally in good health
_____ Has satisfactory sleeping habits
_____ Experiences nightmares
_____ Requires little sleep
_____ Is extremely active
_____ Is quiet, lethargic

_____ Is subject to bedwetting
_____ ear infections
_____ frequent colds
_____ eating problems
_____ high fevers
_____ allergies (explain) _____
_____ Vision problems
_____ Hearing problems
_____ Surgery (explain)_____
_____ Hospitalization (explain)_____
_____ Accidents (explain)_____
_____ Other_____

SOCIAL DEVELOPMENT: (check)

	Often	Sometimes	Rarely
Makes friends easily	_____	_____	_____
Can amuse him/herself	_____	_____	_____
Separates easily from parent	_____	_____	_____
Uses self control	_____	_____	_____
Is confident and self-assured	_____	_____	_____
Finishes one task before starting another	_____	_____	_____
Joins in group activities readily	_____	_____	_____
Can be trusted	_____	_____	_____
Shares Easily	_____	_____	_____

BEHAVIORAL DEVELOPMENT (check)

	Often	Sometimes	Rarely
Bites nails	_____	_____	_____
Sucks thumb	_____	_____	_____
Has temper tantrums	_____	_____	_____
Is overly sensitive	_____	_____	_____
Has a short attention span	_____	_____	_____
Is afraid of new situations	_____	_____	_____
Is fearful	_____	_____	_____
Is very dependent upon others	_____	_____	_____
Naps during the day	_____	_____	_____
Prefers to play alone	_____	_____	_____
Listens to a story read aloud	_____	_____	_____
Watch TV (1 hr. per day)	_____	more _____	_____

DEVELOPMENT HISTORY (check)

Pregnancy: _____ Normal; _____Problems (explain)_____
_____
Medication:_____
_____ Full Term; _____ Premature;
Baby's condition at birth: Birth weight_____
Healthy _____
Complications_____

Specify any medical problems_____

Has your child experienced any unusual emotional stress? If yes, please explain._____
_____
_____

Any history of school or learning difficulties in the family? If yes, please explain._____
_____
_____

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