OAKLAND UNIFIED SCHOOL DISTRICT
*Community Schools, Thriving Students*

**SPECIAL EDUCATION DEPARTMENT**

## I. IDENTIFYING INFORMATION

**Today's date:** _________________

Child's Name: _______________________________ Birth date: ______________ Age: _______ Female/ Male

Address: _______________________________________ Zip Code: ___________ Home School: ___________

Home/Cell/Work Phone: _____________________________________ email: ____________________________

Primary Language spoken at home: _________________________ / ___________ % child is exposed to language

Secondary Language spoken at home: ______________________ / ____________ % child is exposed to language

Language(s) Child speaks at Home: ____________________________________________________________

***Who referred you to our program***? Children's Hospital Oakland Kaiser Regional Center FRN Preschool

Other ______________________________________

Does your child attend preschool/daycare? Yes No Which one? __________________________________

Has your child received any therapies? Yes No Where/Which ones?

__________________________________

_____________________________________________________________________________________

## II. CONCERNS

What are your main concerns about your child? SPEECH COMMUNICATION BEHAVIOR STUTTERING AUTISM

_____________________________________________________________________________________

How old was your child when you first became concerned? _____________________________________

Has your child been diagnosed with any conditions affecting development? No Yes: If yes, please explain.

_____________________________________________________________________________________

**STRENGTHS:**

What are your child's strengths/ what are they good at doing? ___________________________________________

_____________________________________________________________________________________

Describe your child's general disposition: please circle all that apply

| Happy | Moody | Demanding | Irritable | Shy |
|---|---|---|---|---|
| Flexible | Strong | Friendly | Anxious | Active |

Other: ________________________________________________________________________

**III. FAMILY HISTORY**

(circle 1- Mother or Father) Parent's Name: ___________________________Age:___________Education Level: ______

Any learning, developmental, or health problems? If yes, please describe.

(circle 1- Mother or Father) Parent's Name :___________________________Age:__________ Education Level: ________

Any learning, developmental, or health problems? If yes, please describe.

| Names of Siblings | Age | School Attending/ Problems? |
|---|---|---|
| __________________________ | _________ | _________________________________________________ |
| __________________________ | _________ | _________________________________________________ |

Are both parents living in the home? No Yes Who else lives in the home?__________________________________

| Is there a family history of: | NO | YES | Relationship to child |
|---|---|---|---|
| Speech delays | ___ | ___ | __________________________________________________ |
| Developmental delays | ___ | ___ | __________________________________________________ |
| Autism | ___ | ___ | __________________________________________________ |
| Learning disabilities | ___ | ___ | __________________________________________________ |
| Mental Health Problems | ____ | ____ | ___________________________________________________ |
| Hearing Loss | ____ | ____ | ___________________________________________________ |

Have there been any home/family experiences or changes that may have had an impact on your child (divorce, death, frequent residence changes, prolonged illnesses)?__________________________________________________________________

____________________________________________________________________________________________________

| **III. PRE-NATAL HISTORY** | **NO** | **YES** | **DESCRIBE** |
|---|---|---|---|
| Illness during pregnancy | __ | __ | ______________________________________________________ |
| Accidents during pregnancy | __ | __ | ______________________________________________________ |
| Exposure to toxins, x-ray | __ | __ | ______________________________________________________ |
| Cigarettes, alcohol, drugs | __ | __ | ______________________________________________________ |
| Other complications | __ | __ | ______________________________________________________ |
| Medications | __ | __ | ______________________________________________________ |

**IV. NEWBORN INFORMATION**

Full-term Premature: How many weeks? ______ Vaginal delivery Caesarean section- Why?_________________________

Birth Weight: _____________________Problems during birth?___________________________________________________

Condition: Good Jaundice (yellow) Respiratory problems Feeding Problems

Problems/Treatment after birth? No Yes: If yes, please explain (e.g. oxygen, intubation, bilirubin lights, surgery, or extended hospitalization required?).

Any difficulties with feeding or sleeping during newborn period? No Yes ___________________

## VI. HEALTH HISTORY

| Does child have a history of: | NO | YES | DESCRIBE (What/When?) | TREATMENT |
|---|---|---|---|---|
| Ear infections | ___ | ___ | How Many?__________ | _____________ |
| Seizures | ___ | ___ | ______________________________________________ | |
| Surgeries | ___ | ___ | __________________ | ________________________________ |
| Serious illnesses | ___ | ___ | __________________ | ________________________________ |
| Allergies | ___ | ___ | __________________ | ________________________________ |
| Head trauma | ___ | ___ | __________________ | ________________________________ |
| Heart Problems | ___ | ___ | __________________ | ________________________________ |
| Special Syndrome | ___ | ___ | __________________ | ________________________________ |
| Take any medication | ___ | ___ | ____________________________________________________ | |

Other_______________________________________________________________________________

Name of Child's Doctor?______________________________Medical Group:__________________________

| | NO | YES | DATE | By WHOM | RESULTS |
|---|---|---|---|---|---|
| Vision Test | ___ | ____ | ________ | __________________ | ________________ |
| Hearing Test | ___ | ____ | _________ | __________________ | ________________ |

## V. DEVELOPMENTAL MILESTONES

| | Approx. Age | | Approx. Age |
|---|---|---|---|
| Crawled on hands and knees | _____________ | Weaned from pacifier | ____________ |
| Walked without needing support | _____________ | Weaned from bottle | ____________ |
| Spoke first 10 words | _____________ | Toilet trained | ____________ |
| Combined 2-3 words | _____________ | | |

Has your child lost any skills? No Yes: If yes, describe in detail what skills were lost and when ________________________
______________________________________________________________________________________________

## VI. SELF HELP SKILLS

What does your child use to feed themselves? Spoon Fork Hands Parent feeds them

What does your child drink out of? Open Cup Sippy Cup Straw Baby Bottle

Does your child eat what you make or picky?_____________________________________________________

Does your child dress and undress themselves?__________________________________________________

Is your child toilet trained during the day? YES NO Still in Diapers

**VII. LANGUAGE SKILLS**

*RECEPTIVE LANGUAGE SKILLS: UNDERSTANDING LANGUAGE*

1. Does your child point to their body parts (ears, eyes, nose, mouth, etc)?_______________
2. Does your child follow your directions (go throw your garbage in the trash, go bring me your shoes)?____
3. Does your child need you to point to what you are asking him/her to do?_________________________
4. Does your child need you to repeat your questions to understand them?__________________________
5. Does your child follow questions with Who, Where, When?___________________________________

*EXPRESSIVE LANGUAGE: USING GESTURES/ WORDS TO COMMUNICATE*

1. Does your child mostly use words____________________________________________
2. Does your child mostly pull you objects and point to communicate? _______________________
3. Does your child put words together to make up phrases or sentences?____________________________
4. How much of your child's speech to you understand (25%, 50%, 75%, 90%)_______________________
5. Does your child ask questions? _________________________________________________________
6. Does your child suck his/her thumb, fingers, clothes, tongue?________________________________
7. Does your child imitate what you say (repeat what you ask him/her to)? _________________________

*SOCIAL LANGUAGE SKILLS*

1. Does your child play with other children or mostly plays alone? _________________________________
2. Are there any behaviors that you are concerned about? _______________________________________
3. Does your child make eye contact with others?______________________________________________

Any other comments? ____________________________________________________________________
_________________________________________________________________________________________

**Thank you for helping us better understand your child. We look forward to meeting with both you and your child.**

**This form was completed by**_________________________________________
**Relationship to child**_______________________________________________