

Capistrano Unified School District
San Juan Capistrano, California

DEVELOPMENT

PRENATAL

Mother's age at child's birth _____ Any illnesses, injuries or other complications during pregnancy (i.e. toxemia, diabetes, excessive bleeding, surgeries, etc.)

Did you notice high fetal activity during pregnancy? _____

During pregnancy, did mother

- smoke cigarettes use alcohol take medications take hormones use drugs

Please explain: _____

BIRTH

- | | |
|------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> was born with no apparent complications | <input type="checkbox"/> required assistance with breathing |
| <input type="checkbox"/> was born prematurely | <input type="checkbox"/> was born post-maturely |
| <input type="checkbox"/> weighed less than 5 1/2 pounds at birth | <input type="checkbox"/> spent time in a neonatal intensive care unit |
| <input type="checkbox"/> other: _____ | |

DEVELOPMENTAL MILESTONES ACHIEVED

AGE

- | | |
|-------------------------|-------|
| Sitting Alone | _____ |
| Crawling | _____ |
| Standing Alone | _____ |
| Walking Alone | _____ |
| Speaking first words | _____ |
| Using toilet when awake | _____ |
| Staying dry at night | _____ |

LANGUAGE BACKGROUND

Any language other than English spoken in the home? _____

Language(s) spoken by Child _____ Child's dominant language: _____

At what age was Child exposed to English? _____ At what age did Child begin speaking English? _____

HEALTH HISTORY:

Has your child experienced (now or in the past) any of the following (give ages):

- | | | | |
|--------------------------------|-----------------------------------------|---------------------------|----------------------------|
| _____ a hyperactivity disorder | _____ an attention deficit disorder | _____ severe allergies | _____ diabetes |
| _____ asthma | _____ chronic ear infections | _____ seizure disorder | _____ head injuries |
| _____ depression | _____ lead poisoning | _____ fetal alcohol | _____ stomach aches |
| _____ hospitalizations | _____ high fevers | _____ eating disorders | _____ fainting spells |
| _____ anemia | _____ sleeping problems | _____ a motor tic | _____ poor bladder control |
| _____ poor bowel control | _____ self-injurious behavior | _____ a neurological exam | |
| _____ episodes if head banging | _____ frequent urinary tract infections | | |
| _____ other. | _____ | | |

Is your child presently taking any medication prescribed by a physician _____? If yes, please name the medication(s) dose and reason:

Any side effects? _____

Does your child experience hearing problems? _____ Does s/he wear a hearing aide? _____

Does your child experience vision problems? _____ Does s/he wear corrective lenses? _____