SAN FRANCISCO UNIFIED SCHOOL DISTRICT
Student Success Team
Developmental History and Family/Home Study (4.0)

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<thead>
<tr>
<th>Student’s Name</th>
<th>D.O.B.</th>
<th>Grade</th>
<th>School</th>
<th>Date of interview</th>
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Person interviewed/Relationship

Household members living with child

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<th>Relationship</th>
<th>Age</th>
<th>If school-age, attends which school?</th>
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Family or significant people outside the household

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Developmental history

- Length of pregnancy in months _____
- Mother’s age at child’s birth_____  
- Child’s birth weight_____
- Child’s place of birth _______ 
- Type of delivery (normal, C-section, etc) ___________________
- Mother’s pre/post-natal health______________________________________
- Complications or unusual circumstances before/during/after birth? 
  __________________________________________________________________

Baby’s health (first months)

- Walked at age ___________  
- First words spoken at age __________
- Did family notice anything special or different about the child’s growth and development?  
  __________________________________________________________________

Physical Health

- Date of last physical exam ________  
  *Doctor’s name and location ________________________________
- Any problems noted? any recommendations? _________________________
- Date of last vision screening ________  
  Results ___________________________
- Vision problems? (e.g. failed vision screen, lost glasses) ___________________
- Date of last hearing screening ________  
  Results ___________________________
- Problems with hearing? (e.g. ear infections, tubes in ears) ___________________
- Any ongoing medical problems or concerns? ___________________________
- Is the child taking any medication? (prescription, over the counter, or traditional) ______________
- Accidents? major or ongoing illnesses? hospitalizations? ____________________________________________
- Any physical disabilities now or in past? ___________________________
- History of neurological problems? (e.g. seizures, loss of consciousness) ___________________
- Problems related to eating or sleeping? ________________________________
- Problems related toileting? (e.g. bedwetting, etc) ________________________
Emotional health
Does family have any concerns about the child’s behavior and/or emotional health? __________________________

Describe how any experiences in the child’s life, past or present, have affected him/her: ________________________

Any current or prior diagnosis of mental health problems? _________________________________
Any current or prior counseling or therapy? ________________________________
* Mental health provider or counselor’s name __________________________ Location ______________________

Speech and language development
Understands and communicates: well_____ adequately_____ poorly_____
Do you and/or others have difficulty understanding your child’s speech? __________________________
Other speech problems? (stuttering, delayed speech) ______________________________
Please give details (at what age did the problem begin? etc.) ________________________________

Motor Development
Any large movement difficulties (walking, running, etc.) ________________________________
Any small movement difficulties (writing, tying shoes, etc.) ________________________________
Has parent noticed any problems (clumsiness, delays in walking, etc.) ________________________

Social Development and Social Interactions
Has many friends _____ Has some friends _____ Has almost no friends _____ Is isolated _____
Activities at school _________________________________________________________________
Activities outside of school (e.g. religious groups, community organizations, etc.) ______________________

Is your child able to bathe him/herself? _____ dress him/herself? _____ eat on his/her own? _____
Or does your child need help with these daily activities? Who provides this care at home? __________________
Does your child help with any housework or chores? ________________________________
How well or poorly does the student get along with other members of the household? ______________________

What support system(s) is (are) available to the family? (e.g. extended family, neighbors, friends) ________

Language and Cultural Issues
Language(s) spoken at home_________________________ Language student prefers______________
How long have child/family lived in the San Francisco area? ________________________________
Prior place(s) child/family lived? _______________________________________________________
Is there anything about your child’s cultural or religious life that might affect him/her at school, such as
restrictions on certain activities? ________________________________________________________

Other
What are your child’s strengths? What do you like about your child? __________________________

What do you think is the reason for any problems your child may be having at school? _________________

Please give us any other information that would give school staff a better understanding of your child:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature of parent/guardian __________________________ Signature of interviewer __________________________ Name/title of interviewer __________________________

* NOTE: If medical or mental health providers could provide information to help staff support your child in
school, please provide us with a signed consent so that the provider can share that information with us.