



The Colwyck Center 12 Landers Lane New Castle DE 19720 Office 302-429-4055 Fax 302-429-4057

BACKGROUND HISTORY

Child's Name:						
	First		Middle	Last		
Birthdate:	/ /	Age:	Gender: M F	Race:		
Mother's Name: _				Age:		
Father's Name: _				Age: _		
Legal Guardian's I	Name (if appl	icable):		Age:		
Person Completin	g this Form: _					
		Name		Relationship	to child	
With whom does	the child live	?				
Name				Relationship to child		
Parent's or Legal	Guardian's St	reet Address:				
Street	Apt.# (if	applicable)	City	State	Zip Code	
Parent's or Legal	Guardian's Mo	ailing Address (if	different from above):			
Street	Apt.# (if	applicable)	City	State	Zip Code	
Home Phone:			Cell Phone:			
Work Phone (mother):		Work Phone (fat	Work Phone (father):			
Email:						
In which school c	listrict is you	r child's home loca	ated?			
Does your child a	ttend a childe	care/daycare faci	ility? If yes, w	hich childcare/do	aycare facility?	
Name of facility		Address of f	facility			



Language(s) spoken in the home: _____

Other adults living in the home;

Name	Relationship	Name		Relationship
Other children living in the home:				
Name		_ Age:	Relationship	
Name		Age:	Relationship	
Name		Age:	Relationship	
Name		Age:	_ Relationship	

BIRTH HISTORY

Were there any problems during pregnancy? Yes No	
If yes, please explain	
Length of pregnancy: Full Term Premature	
	How many weeks?
Type of delivery: Normal Breech Forceps	Caesarean
Birth Weight: Baby's condition at birth:	
Any complications during delivery? Yes No	
If yes, please explain:	
Length of hospital stay:	
Any complications during hospital stay? Yes No	
If yes, please explain:	



HEALTH HISTORY

Name of your child's physician: _				
	First		Last	
Physician's telephone number: ()			
Has your child's hearing been te	sted? Yes	No	If yes, wher	۲ <u>۲</u>
Results of testing:	_			
Does your child have a history o	f ear infections?)	/es N	10	
If yes, when was the first ear in	ifection?	When was	the most recent ir	nfection?
How often has your child had ea	r infections?			
Frequently	Occasionally	Seldom_	Neve	r
Has your child ever had tubes su	rgically placed? _			
Has your child's vision been test	ed? Yes	No I	f yes, when?	
What were the results of the te	sting?			
Are there any other physicians o	or specialists who	have treated yo	our child? If yes,	please list:
Name	<i>F</i>	Address		Telephone Number
Name	+	Address		Telephone Number
Name		Address		Telephone Number
Does your child have any signific	ant health proble	ms? Yes	No	_
If yes, explain				
T			<u> </u>	
Is your child currently taking an				
If yes, please list:				
. <u>.</u>				



CHILD'S DEVELOPMENT

Do you have concerns about your chi If yes, explain:	d's development? Yes	
Is your child toilet trained? Yes		
Does your child regularly drink from If no, what does he/she use?		
Did/does your child have frequent us		
Does your child have a history of cha		Yes No
Has your child ever received special occupational therapy, physical therap		
If yes, please list:		
Type of service	When	Where
Type of service	When	Where
Type of service	When	Where
SPEEC	H AND LANGUAGE DEV	VELOPMENT
When did your child first use his/he	r first words meaningfully?	
How does your child most frequently	communicate with you? Check	all that apply:
Sounds Single Words	_ Phrases or Sentences	Gestures Pointing
Leads to desired objects Ot	her(please describe)	
How well is your child understood by	others?	
Parents Pa	oor Fair Well	

Siblings Poor____ Fair____ Well____

Playmates Poor____ Fair____ Well____

Does your child use o	at least 50 words? Yes	No	_ If no, how many words? _	
				ø, <u>9</u>
Is your child able to	have a simple conversation w	vith you? Yes _	No	
Does your child have	difficulty understanding oth	her's questions	s or following directions? Ye	es <u>No</u>
If yes, when	have you observed this?			
If your child has dif	ficulty understanding or com	imunicating, ho	ow does he/she react to thi	s difficulty?
-	general course of communicat er Remained the so	,		
	<u>CHILD'</u>	S BEHAVI	OR	
What are your child	s favorite activities or toys?			
Is your child able to	play by himself/herself for	a short time?	Yes No	
Does your child like	to play with other children?	Yes <u>No</u>	-	
Please describe any	frequent behavior problems ·	that you may h	nave with your child:	
What are your child	s strengths?			
	FAMIL	Y HISTOR	<u>RY</u>	
-	tory of speech, language or l be the type of problem and u			



DAYCARE AND PRESCHOOL HISTORY

If your child attends a daycare , please answer the following:
Type: Public Private Home Family Member's Home
Name of Daycare:
Address:
Telephone Number:
Contact Person:
How many days and hours does your child attend daycare? days per week, hours per day.
Has the daycare provider expressed any concerns about your child? Yes No
If yes, please explain:
If your child attends preschool , please answer the following:
Type: Public Private Home
Name of Preschool:
Address:
Telephone Number:
Contact Person:
How many days and hours does your child attend preschool? days per week, hours per day.
Have the preschool teachers expressed any concerns about your child? Yes No
If yes, please explain:
Has your child recently changed daycare or preschool settings? Yes No
If yes, please explain:
Is there anything else you would like the assessment team to know about your child or family?

<u>Culture</u>



It is important to Colonial School District staff members to be respectful to and understanding of all of our families. Please answer the following cultural questions so that we may understand and support your child and your family.

List any special holidays, customs, or celebrations that are important to your child or your family:

List any food items that your child or your family does not eat due to cultural or religious reasons:

List any religious or cultural beliefs that your family has or any information that you would like to share to help our staff better understand your culture and beliefs:

List all languages your child is learning or exposed to in the home: