TUCSON UNIFIED SCHOOL DISTRICT

Child Find Exceptional Education Preschool Office
Duffy Family and Community Center
5145 E. 5th Street
Tucson, AZ 85711
520 232-7035

Child Find Preschool Developmental/Health History

Child's Name: ________________________________ Date of Birth: ____________ Gender: ______ Ethnicity: ____________

Today's Date:__________________ Person Completing Form: ____

Signature: ____ Email: ____

Address: ____

Home Phone: ___________________________________ Cell Phone(s): ____

Primary Language Spoken in Home: ____________________________ Used by the Child: ________________________________

1. What are your primary concerns about your child's development?

____

____

2. Who referred you to Child Find?

Myself (parent(s) _____ Pediatrician/other medical provider _____ AzEIP/DDD Service Coordinator _____ Preschool/Daycare provider _____
Head Start _____Other (please list) ________________________________

Family Information

3. Who does your child live with? ____

4. Is this child: Biological ____ Adopted ____ Foster ____

If adopted or foster placement, enter adoption /placement date: ____________________

5. If foster child, who has custody of child? DCS ____ Relative ____ Tribal entity ____

6. Please indicate whether any member of the child's immediate biological family (i.e., parents/siblings) have experienced any of the following learning, behavioral, neurological, or other mental health problems. (check all that apply)

	Condition	Family Member		Condition	Family Member
	Autism			Cerebral Palsy	
	Speech/Language Impairment			Hearing Impairment	
	Learning Disability			Vision Impairment	
	Cognitive Impairment			Tourette's Syndrome	
	Seizure Disorder			Depression	
	Down Syndrome			Schizophrenia	
	ADHD/ADD			Obsessive/Compulsive Disorder	
	Drug/Alcohol Addiction			Sensory Integration Disorder	
	Other (Please list condition)				

Prenatal and Early Developmental History

7. PREGNANCY If Yes, explain:

Was the mother under a doctor's care? No Yes ____
Illnesses? No Yes ____
Medications? No Yes ____
Toxemia/Preeclampsia? No Yes ____
High Blood Pressure? No Yes ____
Maternal accidents/Injury? No Yes ____
Used tobacco? No Yes ____
Used alcohol? No Yes ____
Used drugs (prescription and/or recreational)? No Yes ____

8. BIRTH/NEONATAL/INFANCY If Yes, explain:

Premature (early)? No Yes # of weeks________
NICU hospitalization? No Yes # of days _________
Oxygen needed? No Yes # of days _________
Other complications? No Yes ____
Medical diagnoses given at birth? No Yes ____
Problem feeding? No Yes ____
Difficulty in weight gain? No Yes ____
Lack of cooing or babbling? No Yes ____
Lack of gesturing? No Yes ____
Lack of eye contact? No Yes ____
Motor problems (e.g., difficulty sitting, rolling, crawling, walking, grasping objects)
No Yes ____
Other (please describe) ____

9. DEVELOPMENTAL MILESTONES (Mark N/A if not yet attained)

	Years	Months		Years	Months
Sat alone	_____	______	Spoke 2-3 words together	_____	______
Crawled	_____	______	Fed self with utensil	_____	______
Walked alone	_____	______	Dressed self	_____	______
Spoke first word	_____	______	Toilet trained	_____	______

Heath/Medical History

10. HOSPITALIZATIONS If yes, Explain

Surgeries? No Yes ____
Illnesses? No Yes ____
Is your child currently on medications? No Yes
If Yes, list names and dosages ____

11. ILLNESSES AND INJURIES If yes, when? Explain:

Frequent colds? No Yes ____
Frequent ear infections? No Yes ____
Tubes in ears? No Yes ____
Frequent headaches? No Yes ____

Frequent stomach aches? No Yes ______________________________
High fevers? No Yes ______________________________
Concussion? No Yes ______________________________
Other head injury? No Yes ______________________________
Loss of consciousness? No Yes ______________________________
Bone fractures? No Yes ______________________________
Other Illnesses/Injuries/Accidents? Please explain:

____

12. CHRONIC HEALTH PROBLEMS If yes, Explain

Allergies? No Yes ______________________________
Asthma? No Yes ______________________________
Seizures? No Yes ______________________________
Heart problems? No Yes ______________________________
Kidney problems? No Yes ______________________________
Eating problems? No Yes ______________________________
Vision problems? No Yes ______________________________
Hearing problems? No Yes ______________________________
Hyperactivity? No Yes ______________________________
Diabetes? No Yes ______________________________
Other health problems? Explain: ______________________________

Educational/Behavioral Information

13. Does your child currently receive, or have they received any services or therapies? (check all that apply)

	Therapy	Services through- *name of provider*	Age received service
	Speech/Language		
	Occupational Therapy		
	Physical Therapy		
	AzEIP		
	Behavior		
	Other		

14. Has your child ever had a *psychological, neuropsychological,* or *neurological* evaluation? No Yes

If yes, when: ______________________________

Provider's name: ______________________________

Reason for evaluation: ______________________________

15. Does your child currently attend childcare or preschool? No Yes

Hours per week ____________ Name of School ______________________________

Name of Teacher/Provider______________________________

16. When your child is upset or frustrated, he/she will: (check all that apply)

Cry Hit Scream Bite Kick Scratch Run Hide Other____________________________

17. Is your child overly sensitive to: (check all that apply)

Sounds Lights Textures Touch Large Groups Other______________________________

18. Does your child wear glasses, use hearing aids or any other assistive equipment? ____________________________

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19. Please indicate if your child does the following:

Adaptive Skills	**No**	**Yes**	**Explain**
Can put on or take off clothing			
Toilet trained			
Eats with fork/spoon			
Drinks from a cup or glass			
Social Emotional Skills			
Plays with others			
Makes eye contact			
Shares toys/materials with others			
Is impulsive, lacks self-control			
Is hyperactive/over-stimulated during play			
Has difficulty paying attention/is distractible			
Fights or is aggressive towards others			
Prefers to play alone			
Has frequent temper tantrums			
Is wary of new situations or people			
Is often non-compliant to adult directions			
Communication Skills			
Has speech difficulties			
Has difficulty using language to communicate with adults/peers			
Has difficulty understanding/following directions			
Cognitive Skills			
Knows shapes/colors			
Can count 1-5 or more			
Learning letters/numbers			
Physical Skills			
Climbs playground equipment			
Can draw lines/circles			

20. How does your child communicate? (check all that apply)

Pointing Pulling/Pushing Gestures/Signs Makes Sounds Words/Phrases

21. Please provide any additional comments that you feel may be useful to the evaluation team.

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