Long County School System
Pyramid of Interventions
BACKGROUND INFORMATION
(To be completed by parents or guardian)

Dear Parent: We would appreciate your help in completing this information regarding _____ and returning it to the school. The information will help us in working more effectively with your child. Information on this form will be treated in a confidential manner.

Child's Name: _____ Date today: _____
First *Middle* *Last*

Address: _____ Birthdate:_____

Name of parent or guardian with whom child lives: _____ Home Phone #: _____

Agencies or specialists that have worked with this child or family:
Mental Health Clinic: ____ Clinical Psychologist: ____ Psychiatrist: ____ Social Worker: ____ Therapist: _____
Other (specify): _____

If any checked, please give the following information:

NAME	ADDRESS	DATE(S) SEEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY DATA

Mother's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Father's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Step-Parent's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Marital Status of Parents: _____

If parents are separated or divorced, how old was child when the separation occurred? _____

List all people living in household:

Name:	*Relationship to Child*	*Age*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages:

Name	*Age*
_____	_____
_____	_____
_____	_____

Did your child attend preschool? If so, name of Pre-K program: _____

SCHOOL HISTORY

Number of years attended this school (circle one): 1 2 3 4 5 6 7 8

Grades Repeated: _____

Other Schools Attended: _____
_____

Describe any serious problems your child has had at school: _____
_____

Describe any serious problems your child has had at home: _____
_____

BIRTH HISTORY

List any illnesses or problems occurring during pregnancy. _____
_____

Full Term: Yes No Birth weight: _____

Delivery: *Normal Breech Cesarean* *Complications:* _____
_____

Was there any evidence of injury at birth? Yes No Explain: _____

Were any of the following experienced before the child's fifth birthday? ____Ear Infections ____Convulsions

Other: _____ ____Serious Accidents ____Head Injuries

Please give additional information on any item checked above: _____
_____
_____

DEVELOPMENTAL DATA

At what age did the following behaviors first occur?

_____Crawled
_____Sat alone
_____Walked alone
_____Said first words besides "Ma-Ma" and "Da-Da"
_____Speech was clearly understood by others outside the family
_____Toilet trained during day
_____Toilet trained during night
_____Tied shoes
_____Dressed self
_____Slept alone

PHYSICAL CONDITION

My child's general condition is:

Seems to be in good health	Tires easily, listless, lacks energy
Overweight	Sleeps too much
Underweight	Sleeps too little
Overly active; always on the move	Awkward in running, walking, or playing

List any physical handicaps, serious illnesses, hospital stays, accidents or head injuries (vision, hearing, speech, seizures, operations, diseases, etc. _____
_____
_____
_____
_____

Is your child on any prescription medication? Yes No If so, what? _____

Physician's name: _____

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

____Feels happy with him/herself
____Demands excessive attention
____Plays well with other students
____Exhibits uncooperative attitude
____Has very few close friends
____Lacks motivation, lazy
____Does not adjust readily to change
____Acts younger than other children his/her age
____Can be trusted
____Loud
____Sucks his/her thumb
____Overly dependent on others
____Overly anxious to please
____Tries to control others
____Relates well to adults
____Aggressive
____Fearful
____Openly affectionate to family members
____Restless
____Wets the bed
____Cries often
____Poor self-control
____Friendly
____Sad or depressed often
____Shy, withdrawn
____Daydreams often
____Easily frustrated
____Jealous of brother(s)sister(s)

If you wish to add additional information, please add it below or attach to this form. Thank you for your input.

_____ _____
Parent/Guardian's Signature *Date*