

## SOCIAL WORK ASSESSMENT

Student Name:	ID#:	DOB:
School:	Grade:	Teacher Name:
Respondent's Name:		Relationship to Student:

### Family Composition

Names of Family Member(s)	Relationship to Student	Living in the home (Y/N)	Age	Academic Level Achieved

### Parent's/Guardian's Marital Status

<input type="checkbox"/> Single	<input type="checkbox"/> Married Date: _____	<input type="checkbox"/> Separated Date: _____	<input type="checkbox"/> Divorced Date: _____	<input type="checkbox"/> Widowed Date: _____
Additional Comments: _____				

### Family Personal Data

Home Address:	Home Phone Number:	Primary Language Spoken in Home:
At Address Since:		
Employment:	Work Schedule:	Position:
	Work Contact Phone Number:	Other method(s) of assistance: <input type="checkbox"/> TANF <input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> SSI
Additional Contact Name(s)/ Relation / Phone Number(s):	Insurance Type:	Means of Transportation:

## Early History/Development

### *Labor and Delivery*

Gestation (months):	Birth weight:	Length of labor:	Natural <input type="checkbox"/> C-Section <input type="checkbox"/>
Induced <input type="checkbox"/> Forceps <input type="checkbox"/>	Position at birth: Head First <input type="checkbox"/> Breeched <input type="checkbox"/> Feet First <input type="checkbox"/>		
If premature, was child in an incubator? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long?	Was child born at hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, length of stay:	Was child born at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the child suffer from any complications during birth? If yes, explain:	Was the child exposed to any of the following during pregnancy? <input type="checkbox"/> drugs <input type="checkbox"/> alcohol		
Is the child presently experiencing and/or has he/she ever experienced developmental delays in the following areas? <input type="checkbox"/> gross motor <input type="checkbox"/> fine motor <input type="checkbox"/> cognitive <input type="checkbox"/> language <input type="checkbox"/> social <input type="checkbox"/> Duration: Describe:			

### *Early Development and Milestones*

<p><b>Adjustment stages</b></p> <p>Feeding:</p> <p> </p> <p>Weaning:</p> <p> </p> <p>Sleep History:</p> <p> </p>	<p><b>Did child exhibit the following pattern behaviors?</b></p> <p>Habits   <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:</p> <p> </p> <p>Fears   <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:</p> <p> </p> <p>Phobias   <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:</p> <p> </p> <p>Tantrums   <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:</p>
<p><b>Achievement of developmental milestones</b></p> <p>Crawling:</p> <p> </p> <p>Sitting:</p> <p> </p> <p>Standing:</p> <p> </p> <p>Walking:</p> <p> </p> <p>First Words:</p> <p> </p> <p>Early Play:</p> <p> </p> <p>Toilet Training:</p> <p> </p>	<p><b>Sexual development</b></p> <p>Puberty:</p> <p> </p> <p>Menarche:</p> <p> </p> <p><b>Additional behaviors</b></p> <p>Any instances of fire-setting?   <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> </p> <p>Any instances of cruelty to animals? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> </p> <p>Other:</p> <p> </p>

## Student Medical / Mental Health History

Does the child have any health problem(s)/syndrome(s)? If <b>yes</b> , explain:
Current medication and dose the child is taking:
Treatment history (medical/psychological/mental health):

Vision Impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Wears Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Speech/language impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Unusual speech patterns? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sensory sensitization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Been in an accident/hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Suffered head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious fall? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes to any of the above, was there: <input type="checkbox"/> Nausea <input type="checkbox"/> Unconsciousness <input type="checkbox"/> Headaches <input type="checkbox"/> Diagnosed Concussion			
Any change in behavior and/or learning ability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Is there a family history of medical/mental health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Has the child demonstrated self-injurious behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			

### Interpersonal and Family Relationships / Behavior

Describe the child's overall behavior at home:			
Does the child have temper tantrums? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the child cry easily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How do you handle the above? What do you do when your child misbehaves?			
What do you do when the child behaves well?			
Who does the child feel closest to?			
Has the child suffered a trauma as a result of a divorce, death, incarceration? If <b>Yes</b> , explain:			
Has the child experienced a traumatic life event (e.g., natural disaster, witness to violent act, victim of crime)? Explain:			
If applicable, does the child have contact with the absent parent(s)? Describe:			
Does your child like to be with people? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does child spend time alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does child have good daily living skills? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is child responsible for household chores? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does child play well with others? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does he/she have friends? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does child play with younger or older children? <input type="checkbox"/> Younger <input type="checkbox"/> Older	
Describe the child/peer relationship:			

Is the child aggressive? <input type="checkbox"/> Yes <input type="checkbox"/> No, if <b>yes</b> describe:	Does the child exhibit repetitive behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No, if <b>yes</b> describe:
Does child experiment with drug or alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No, if <b>yes</b> describe:	
Does the child demonstrate violent behavior (e.g., threats, towards other people and/or animals)? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe:	
Is there a familial history of learning problems? if <b>yes</b> , specify.	
Has there been any instance of physical abuse, neglect, sexual abuse? if <b>yes</b> , specify.	

### Environmental, Language & Cultural factors

Child's place of birth:	Age child arrived to U.S.:
Multi languages/dialects spoken in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
School condition in the home country: <input type="checkbox"/> City based <input type="checkbox"/> Rural <input type="checkbox"/> Single class <input type="checkbox"/> Graded levels	
What is the primary language spoken in the home by the student? Does the child have difficulty speaking his/her native language?	
Has the child experienced any acculturation issues? Explain:	
Has the family been homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , when and for how long?	

### School Information

Age entered school:	Grade entered public school:	Has student been retained: <input type="checkbox"/> Yes <input type="checkbox"/> No Which grade(s)?
Previous schools attended:	School problems: Behavior <input type="checkbox"/> Learning <input type="checkbox"/> Homework <input type="checkbox"/> Attendance <input type="checkbox"/> Bullying <input type="checkbox"/> Other <input type="checkbox"/> Explain:	
Education perceived as: <input type="checkbox"/> Critical <input type="checkbox"/> Important <input type="checkbox"/> Required <input type="checkbox"/> Unimportant		
Does the child report having a fear or dislike of school? Explain:		

