

Medical/Social/Emotional History



Circle One ►	New TCAPS Enrollee: (Circle) Daycare Preschool K 1 2 3 4 5 6
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Student:	
Birth date:	
Parent/Guardian:	
This form completed by:	
Relationship to student:	Child lives with:
Child's Health Care Provider:	
Signature:	Date:

To be completed by TCAPS employee:

Reviewed by:	Phone:
Action:	

PREGNANCY/BIRTH HISTORY:

Length of pregnancy: _____ Describe prenatal care:		
Mother's health during pregnancy: complications, toxemia, high blood pressure, anemia, infections, etc. (circle all that apply)		
Drugs/Medications used during pregnancy:		
Amount of alcohol ingested weekly:	Tobacco:	
Length of labor:	Circle: C-Section / Vaginal / Vacuum / Forceps	
Did baby breathe right away?		
Weight:	Length:	APGARs:
Jaundice:	Light therapy:	Did baby go home with mother? YES/ NO
Any problems after delivery?		

DEVELOPMENTAL HISTORY:	MONTHS/YEARS
Age child sat up:	
Age child crawled:	
Age child walked alone:	
Age child spoke his/her first words:	
Age child spoke well enough to be understood by others:	
Age child rode bicycle:	

Hand dominance:	Left	Right
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My child seems to have poor coordination.	NO	YES
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SOCIAL/EMOTIONAL HISTORY:	NO	YES
My child is having difficulty learning/developing up to his/her potential.		
My child seems to have trouble sleeping, has nightmares or night- terrors. (Circle those that apply)		
My child has difficulty sitting still, concentrating or paying attention to things. (Circle those that apply)		
My child has difficulty making or keeping friends.		
My child is easily agitated, frustrated, or has problems with aggression. (Circle those that apply)		
My child is having difficulty coping with something stressful or traumatic.		
My child has excessive worries, fears, anxiety or shyness. (Circle those that apply)		
My child grinds his/her teeth, has tics or twitches. (Circle those that apply)		

	NO	YES
My child rocks repetitively or, bangs his/her head. (Circle those that apply)		
My child seems very sad or depressed at times.		
My child has significant behavior problems.		
My child has seen a social worker, counselor, therapist, psychologist or psychiatrist. (Circle those that apply)		
COMMENTS: Please use this section to give information on any "YES" answers.		
Preschool experience:		
Eating habits:	Height:	Weight:
Sleeping pattern: Naps / Number of hours typically asleep at night:		
Child's strengths:		
Describe restrictions that keep your child from participating in school activities:		
MEDICINE(S) TAKEN AT HOME: Medicine: _____ Dose: _____ Times: _____ Reason: _____		
MEDICINE(S) TO BE TAKEN AT SCHOOL: Medicine: _____ Dose: _____ Times: _____ Reason: _____		
ACCIDENTS, OPERATIONS, HOSPITALIZATIONS: Age of child: _____ Please describe: _____		
FAMILY HISTORY: Circle: Inheritable diseases / Diabetes / Epilepsy / A.D.H.D. / Alcoholism / Depression / Learning Disabilities / Asthma / Heart Disease / Etc: _____ COMMENTS:		

