EDUCATION HISTORY

<table>
<thead>
<tr>
<th>RDN Participant ID:</th>
<th>Date of Registration: (dd mmm yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Subject ID:</td>
<td>Status</td>
</tr>
<tr>
<td>Site ID:</td>
<td>Date of Visit</td>
</tr>
</tbody>
</table>

**Education History to Date:**

Highest grade completed by your child or currently enrolled in:

- [ ] Not yet in school
- [ ] Pre-K
- [ ] Kindergarten
- [ ] Grade: ______ Specify Grade
- [ ] GED
- [ ] Special High School Certificate
- [ ] Vocational training
- [ ] Junior College
- [ ] College
- [ ] Other________________

Has your child ever been in special classes?  
- [ ] Yes  
- [ ] No

What type(s)?

- [ ] Exceptional Student Education (ESE)
- [ ] Varying Exceptionalities (VE)
- [ ] Severe Emotionally Disturbed (SED)
- [ ] Regular Classroom with Accommodations (Inclusion)
- [ ] Other________________

Has your child ever been held back a grade?  
- [ ] Yes  
- [ ] No

If so, which grade(s)? ________

Has your child ever had IQ testing outside of the research study?  
- [ ] Yes  
- [ ] No

*If so, Score________ Name of test (if known) _____________________

Child’s age at time of test ___________ years

Score________ Name of test (if known) _____________________

Child’s age at time of test ___________ years

Score________ Name of test (if known) _____________________

Child’s age at time of test ___________ years
Does your child have known learning, developmental or physical handicaps diagnosed by a professional (e.g., physician, psychologist, teacher, etc.)?  O Yes  O No  O Not sure

What type(s)?  (Indicate all that apply)
- Speech and language
- Specific learning disability MATH
- Specific learning disability READING
- Learning disabled
- Developmental delay
- Severe behavior problems
- Emotional disturbances
- Multiple disabilities
- Visually impaired
- Hearing impaired
- Other health impaired
- Traumatic brain injury

Does your child have any special strengths or skills (that you would like to mention)?
O Yes  O No  (please list below)

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Has your child ever been given any of the following diagnoses?  (Indicate all that apply)
- Attention Deficit Disorder
- Attention Deficit Hyperactivity Disorder
- Pervasive Developmental Disorder
- Conduct Disorder
- Oppositional Defiant Disorder
- Autism
- Obsessive Compulsive Disorder
- Other ________________________________

Related Services:
Has your child ever received any of the following?

Occupational Therapy  O Yes  O No
If yes, when did therapy start?  Date ___/____/______
Has your child continued to receive this therapy?  O Yes  O No
If no, for how long did they receive therapy?  ____years

Physical Therapy  O Yes  O No
If yes, when did therapy start?  Date ___/____/______
Has your child continued to receive this therapy?  O Yes  O No
If no, for how long did they receive therapy?  ____years
Speech Therapy

☑ Yes ☐ No
If yes, when did therapy start? Date ___/____/______
Has your child continued to receive this therapy? ☑ Yes ☐ No
If no, for how long did they receive therapy? ____ years

Language Therapy

☑ Yes ☐ No
If yes, when did therapy start? Date ___/____/______
Has your child continued to receive this therapy? ☑ Yes ☐ No
If no, for how long did they receive therapy? ____ years

Sensory Integration Therapy

☑ Yes ☐ No
If yes, when did therapy start? Date ___/____/______
Has your child continued to receive this therapy? ☑ Yes ☐ No
If no, for how long did they receive therapy? ____ years