EDUCATION HISTORY

RDN Participant ID:		Date of Registration: (dd mmm yyyy)	
Local Subject ID:		Status	
Site ID:		Date of Visit	

Education History to Date:

Highest grade completed by your child or currently enrolled in:

- O Not yet in school
- O Pre-K
- O Kindergarten
- O Grade: _____ Specify Grade
- O GED
- O Special High School Certificate
- O Vocational training
- O Junior College
- O College
- O Other_____

Has your child ever been in special classes? O Yes O No

What type(s)?

- O Exceptional Student Education (ESE)
- O Varying Exceptionalities (VE)
- O Severe Emotionally Disturbed (SED)
- O Regular Classroom with Accommodations (Inclusion)
- O Other_____

Has your child ever been held back a grade? O Yes O No

If so, which grade(s)? _____

Has your child ever had IQ testing outside of the research study? O Yes O 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

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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

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Speech 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

Language 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

Sensory Integration 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