

**RANKIN COUNTY SCHOOL DISTRICT
DEVELOPMENTAL HISTORY (Ages 3-9)**

NOTE: The information collected on this form will be used by your child's school to help them determine your child's educational needs. Please include any information you think will help us in understanding your child.

Informant:	Relationship to the Child:
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PERSONAL DATA

Child's Name:	Race/Ethnicity:	Gender:	DOB:
School:	MSIS #:	Grade:	Age:

HOME AND FAMILY INFORMATION

Parent(s)/Guardian(s):		Age:
Home Address:		Home Phone:
		Work Phone:
Child lives with:	<input type="checkbox"/> Birth Parent(s) <input type="checkbox"/> Adoptive Parent(s) <input type="checkbox"/> Parent and Step-Parent <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Other: _____	

Persons Living in the Home

#	Name	Age	Gender	Relationship	Special Needs
1.					<input type="checkbox"/> Yes <input type="checkbox"/> No
2.					<input type="checkbox"/> Yes <input type="checkbox"/> No
3.					<input type="checkbox"/> Yes <input type="checkbox"/> No
4.					<input type="checkbox"/> Yes <input type="checkbox"/> No
5.					<input type="checkbox"/> Yes <input type="checkbox"/> No
6.					<input type="checkbox"/> Yes <input type="checkbox"/> No

Language(s) Spoken in the Home

Is any language other than English spoken in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Language(s)	Child		Parent(s)/Guardian(s)	
	Understands	Speaks	Understands	Speaks
English				

Your Child's Strengths

Describe your child's strengths.

Concerns for Your Child

Describe any concerns that you have or any recent changes in your child's development, behavior, or learning (e.g., missing developmental milestones, inattention, angry outbursts, withdrawn, difficulty learning information).

Life Events or Family Transitions

Describe any major life events or changes in the family situation that may have affected your child (e.g., abuse, accidents, change in guardianship, death of a family member, divorce, economic hardship, family move, natural disasters, remarriage, separations, etc.).

MEDICAL / PHYSICAL DEVELOPMENT

Birth History

Mother's age at birth: _____ years

Mother received prenatal care during pregnancy? Yes No

Were there any complications during pregnancy or delivery? Yes No

- High blood pressure/toxemia
- Maternal injury/illness
- Exposure to alcohol/cigarettes /drugs
- Rubella/German measles
- Gestational diabetes
- Emergency C-section
- Premature (___ weeks gestation)
- Low birth weight (indicate one: <2.3 lbs. 2.3-3.3lbs 3.4-5.4 lbs.)
- Other: _____

Did your child have an extended stay in the hospital after birth? Yes No (skip to next question)

Length of time: < one week one to four weeks one month or more (___ months)

Reason: _____

General Health

Has your child been hospitalized or had any significant operations? Yes No (skip to next question)

Explain: _____

Has your child had any significant medical conditions or illnesses? Yes No (skip to next question)

- Eye or vision problems
- Heart problems
- Hydrocephalus, hemorrhages, and/or shunt
- Ear infections and/or ear tubes
- Seizures/neurological issues
- Allergies (specify: _____)
- Asthma or breathing difficulties
- Significant infections (e.g., meningitis, encephalitis, etc.) or high fevers
- Other: _____

Has your child had any significant accidents/injuries (e.g., head injuries)? Yes No (skip to next question)

- Motor vehicle accident(s)
- Fall-related injury(ies)
- Significant blow(s) to the head

Other: _____

Explain: _____

Has your child had any difficulties or disorders with the following? Yes No (skip to next question)

- Eating difficulties/disorders
- Sleeping difficulties/disorders
- Toileting difficulties/disorders

Explain: _____

Is your child currently being treated for a medical condition? Yes No

Does your child have a regular healthcare provider/medical home? Yes No

When was your child's last visit to a healthcare provider? Indicate one: <6 months 6-12 months >1 year

Is your child currently taking any medications? Yes No

List: _____

Has your child ever received speech, physical, or occupational therapy? Yes No (skip to next question)

Explain: _____

Hearing and Vision

Has your child ever had his/her hearing and/or vision tested? Yes No (skip to next question)

- Hearing only
- Vision only
- Hearing and vision

Hearing results: _____

Vision results: _____

Does your child require devices to assist with hearing or vision? Yes No (skip to next question)

- Hearing aids (when acquired: _____)
- Glasses (when acquired: _____)

Motor Development

Describe any concerns you have about your child's gross motor skills (e.g., walking, hopping, jumping, running, climbing stairs, kicking balls, etc.).

Describe any concerns you have about your child's fine motor skills (e.g., writing or coloring, working buttons/zippers, tying shoes, cutting, etc.).

Describe any additional concerns you have about your child's physical development.

EDUCATIONAL BACKGROUND

Has your child ever attended a preschool program or childcare center? Yes No (skip to next question)

Name: _____ Phone: _____
Address: _____ Teacher: _____

Describe any difficulties your child has had with learning activities.

Has your child ever been evaluated/assessed/tested for learning difficulties? Yes No (skip to next section)

By whom: _____ When: _____
Results: _____

COGNITIVE / ADAPTIVE DEVELOPMENT

Can your child follow directions? Yes No (skip to next question)

One-step directions only Two-step directions Multi-step directions

Does your child know any of the following information about him/herself?

Name Age Gender
 Parent(s) name(s) Address Home phone number

Does your child:

Identify parts of the body Identify colors Count (highest number: _____)
 Identify letters of the alphabet Play with building toys/puzzles Identify size (e.g., big, little, tall, short, etc.)
 Looks at books independently Enjoy being read to Identify shapes (e.g., circle, square, etc.)
 Recognize written words Read books independently Identify money (e.g., dime, quarter, dollar)

Does your child independently:

Drink from a cup without spilling Dress self completely Use toilet without accidents during day
 Eat with a spoon and fork Put shoes on correct feet Use toilet without accidents during night
 Brush hair and teeth Put on a coat/jacket Clean table/space after eating/activity
 Bathe self Make up bed Cross the street safely

Describe any additional concerns you have about your child's thinking or daily living skills.

COMMUNICATION DEVELOPMENT

Does your child seem to understand what is said to her/him? Yes No

If no, explain:

How does your child communicate?

Gestures only Gestures and some speech Primarily speech with some gestures

Does your child...

Make up stories/songs Talk about daily activities Use "me," "you," plurals, and past tense

Who can understand what your child says? (check all that apply)

Family/caregivers Other children Unfamiliar adults

Describe any additional concerns you have about your child's language or speech skills.

SOCIAL / EMOTIONAL DEVELOPMENT

In the first three years, was/did your child:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficult to calm/comfort | <input type="checkbox"/> Resist being cuddled | <input type="checkbox"/> Show fascination with specific objects |
| <input type="checkbox"/> Excessively irritable | <input type="checkbox"/> Fail to make eye contact | <input type="checkbox"/> Engage in frequent head banging |
| <input type="checkbox"/> Have poor sleep routines | <input type="checkbox"/> Fail to look at caregivers | <input type="checkbox"/> Difficult to feed/nurse |

If any of these behaviors have continued beyond age 3, give an example:

Describe your child's behavior (compared to other children his/her age):

- | | | | |
|--|--|---|---|
| How active is your child? | <input type="checkbox"/> less active than others | <input type="checkbox"/> about the same | <input type="checkbox"/> more active |
| How well does your child pay attention? | <input type="checkbox"/> less distracted than others | <input type="checkbox"/> about the same | <input type="checkbox"/> easily distracted |
| How does your child handle change? | <input type="checkbox"/> handles change easily | <input type="checkbox"/> about the same | <input type="checkbox"/> resists change |
| How does your child respond to new things? | <input type="checkbox"/> readily accepts new things | <input type="checkbox"/> about the same | <input type="checkbox"/> resists new things |
| How strong are your child's emotions? | <input type="checkbox"/> passive/indifferent | <input type="checkbox"/> about the same | <input type="checkbox"/> very intense |
| How moody is your child? | <input type="checkbox"/> very easygoing | <input type="checkbox"/> about the same | <input type="checkbox"/> very changeable |
| How predictable is your child? | <input type="checkbox"/> unpredictable | <input type="checkbox"/> about the same | <input type="checkbox"/> rigid routines |

Indicate if your child has had any of the following difficulties:

- | | | |
|--|---|--|
| <input type="checkbox"/> Refuses to follow directions | <input type="checkbox"/> Withdrawn or keeps to self | <input type="checkbox"/> Cries easily or whines frequently |
| <input type="checkbox"/> Aggression/fighting | <input type="checkbox"/> Extremely fearful or nervous | <input type="checkbox"/> Explosive outbursts or impulsive |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Depressed or very unhappy | <input type="checkbox"/> Stealing or lying |
| <input type="checkbox"/> Destructive behavior/starts fires | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Frequently complains of aches/pains |

For any difficulties identified, give an example:

Does your child play with siblings or other children? Yes No

Describe how your child plays with siblings or other children?

- | | |
|--|---|
| <input type="checkbox"/> plays near—not with—others (e.g., dolls, cars) | <input type="checkbox"/> plays together with others (e.g., chase/tag games) |
| <input type="checkbox"/> plays turn-taking games (e.g., hide-and-seek, hopscotch) | <input type="checkbox"/> plays games with rules (e.g., board games, sports) |
| <input type="checkbox"/> plays make-believe or role-playing games (e.g., playing house, cops and robbers, recreating scenes from movies) | |

Describe any additional concerns you have about your child's social-emotional development or behavior.

ADDITIONAL INFORMATION

Please provide any additional information that would help us understand your child better.

What is the best day and time to contact you?

What is the best day and time to arrange a meeting with you?

Interview completed by: _____

Date: _____