# 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:** |
|---|---|

**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:**<br>**Work Phone:** |

**Child lives with:**
- ☐ Birth Parent(s)
- ☐ Adoptive Parent(s)
- ☐ Parent and Step-Parent
- ☐ Grandparent(s)
- ☐ Foster Parent(s)
- ☐ Other: ____________

**Persons Living in the Home**

| Name | Age | Gender | Relationship | Special Needs |
|---|---|---|---|---|
| 1. | | | | ☐ Yes ☐ No |
| 2. | | | | ☐ Yes ☐ No |
| 3. | | | | ☐ Yes ☐ No |
| 4. | | | | ☐ Yes ☐ No |
| 5. | | | | ☐ Yes ☐ No |
| 6. | | | | ☐ Yes ☐ No |

**Language(s) Spoken in the Home**

**Is any language other than English spoken in the home?** ☐ Yes ☐ 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your child's development, behavior, or learning (e.g., missing developmental milestones, inattention, angry outbursts, withdrawn, difficulty learning information).*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:**

| | | |
|---|---|---|
| ☐ Difficult to calm/comfort | ☐ Resist being cuddled | ☐ Show fascination with specific objects |
| ☐ Excessively irritable | ☐ Fail to make eye contact | ☐ Engage in frequent head banging |
| ☐ Have poor sleep routines | ☐ Fail to look at caregivers | ☐ 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? | ☐ less active than others | ☐ about the same | ☐ more active |
| How well does your child pay attention? | ☐ less distracted than others | ☐ about the same | ☐ easily distracted |
| How does your child handle change? | ☐ handles change easily | ☐ about the same | ☐ resists change |
| How does your child respond to new things? | ☐ readily accepts new things | ☐ about the same | ☐ resists new things |
| How strong are your child's emotions? | ☐ passive/indifferent | ☐ about the same | ☐ very intense |
| How moody is your child? | ☐ very easygoing | ☐ about the same | ☐ very changeable |
| How predictable is your child? | ☐ unpredictable | ☐ about the same | ☐ rigid routines |

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

| | | |
|---|---|---|
| ☐ Refuses to follow directions | ☐ Withdrawn or keeps to self | ☐ Cries easily or whines frequently |
| ☐ Aggression/fighting | ☐ Extremely fearful or nervous | ☐ Explosive outbursts or impulsive |
| ☐ Cruelty to animals | ☐ Depressed or very unhappy | ☐ Stealing or lying |
| ☐ Destructive behavior/starts fires | ☐ Easily frustrated | ☐ 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?

☐ plays near—not with—others (e.g., dolls, cars)
☐ plays together with others (e.g., chase/tag games)
☐ plays turn-taking games (e.g., hide-and-seek, hopscotch)
☐ plays games with rules (e.g., board games, sports)
☐ 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: ______________