

**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.*

<b>Informant:</b>	<b>Relationship to the Child:</b>
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**PERSONAL DATA**

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

**HOME AND FAMILY INFORMATION**

<b>Parent(s)/Guardian(s):</b>		<b>Age:</b>
<b>Home Address:</b>		<b>Home Phone:</b>
		<b>Work Phone:</b>
<b>Child lives with:</b>	<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**

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your child's development, behavior, or learning (e.g., missing developmental milestones, inattention, angry outbursts, withdrawn, difficulty learning information).*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

- 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?                  | <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: \_\_\_\_\_