

**CLAIBORNE 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. It is not required for you to complete this form. If there are any questions you do not wish to answer or you feel uncomfortable answering, feel free to leave them blank. 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>District/School: CCSD/</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>Employer/Occupation:</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 (skip to next section)				
Language(s)	Child		Parent(s)/Guardian(s)	
	Understands	Speaks	Understands	Speaks
English				

Your Child's Strengths
<i>Describe your child's strengths.</i>

Concerns for Your Child
<i>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your child's development, behavior, or learning (e.g., missing developmental milestones, inattention, angry outbursts, withdrawn, difficulty learning information).</i>

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**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 (skip to next question)

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 (skip to next question)

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  
May we access your child's medical records?    Yes (please complete a release form)    No  
Is your child currently taking any medications?    Yes    No  
Explain: \_\_\_\_\_

**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.).*

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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 (skip to next question)  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.

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**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 (skip to next question)

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?**

Form completed by \_\_\_\_\_

Date completed \_\_\_\_\_

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