

**CLAIBORNE COUNTY SCHOOL DISTRICT  
DEVELOPMENTAL HISTORY (Ages 10 – 21)**

**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: Claiborne County School District</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**

*Describe your child's strengths.*

**Concerns for Your Child**

*Describe any concerns that you have or any recent changes in your child's behavior, learning, or functioning (e.g., inattention, angry outbursts, withdrawn, difficulties with school work, difficulties with adults or peers, etc.).*

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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.).*

*Describe any involvement your child has had with State/local agencies (e.g., mental health, human services, juvenile justice, etc.).*

**MEDICAL / PHYSICAL**

**Developmental**

*Describe any problems in birth or early childhood that may have impacted your child's development.*

**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)

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

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Motor vehicle accident(s) | <input type="checkbox"/> Fall-related injury(ies) | <input type="checkbox"/> Significant blow(s) to the head |
| <input type="checkbox"/> Other: _____              |   |  |

Explain: \_\_\_\_\_

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

- |  |  |
|--|--|
| <input type="checkbox"/> Eating difficulties/disorders | <input type="checkbox"/> Sleeping 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 physical or occupational therapy?**  Yes  No (skip to next question)

Explain: \_\_\_\_\_

**Hearing and Vision**

**Does your child have normal hearing and vision?**  Yes (skip to next question)  No

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Problems with hearing only | <input type="checkbox"/> Problems with vision only | <input type="checkbox"/> Problems with hearing <u>and</u> vision |
|---|--|--|

Hearing difficulties: \_\_\_\_\_

Vision difficulties: \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Hearing aids (when acquired: _____) | <input type="checkbox"/> Glasses (when acquired: _____) |
|--|---|

**Physical Functioning**

*Describe any concerns you have about your child's physical functioning.*

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EDUCATIONAL / COGNITIVE		
<b>Can your child follow multi-step directions?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next question)		
<b>Does your child regularly need:</b> <input type="checkbox"/> significant help with homework <input type="checkbox"/> afterschool tutoring <input type="checkbox"/> significant help organizing their school work <input type="checkbox"/> follow-up to ensure s/he completes homework <input type="checkbox"/> instructions or directions to be repeated or explained		
<b>Indicate any areas that your child has difficulties with:</b> <input type="checkbox"/> Getting along with teachers <input type="checkbox"/> Basic math calculations <input type="checkbox"/> Reading aloud, pronouncing words <input type="checkbox"/> Planning ahead/solving problems <input type="checkbox"/> Figuring money, time, etc. <input type="checkbox"/> Understanding what s/he reads <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____		
<i>Describe any difficulties your child has with thinking or learning activities.</i>		
<b>Has your child ever been evaluated/assessed/tested for learning difficulties?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next section) By whom: _____      When: _____ Results: _____		
ADAPTIVE		
<b>Does your child independently:</b> <input type="checkbox"/> Groom his/herself appropriately <input type="checkbox"/> Run errands for the family <input type="checkbox"/> Take care of his/her possessions <input type="checkbox"/> Complete chores at home <input type="checkbox"/> Handle money/make change <input type="checkbox"/> Take care of younger siblings or relatives		
<i>Describe any concerns you have about your child's daily living skills.</i>		
COMMUNICATION		
<b>Indicate any areas that your child has difficulties with:</b> <input type="checkbox"/> Articulation (e.g., pronouncing sounds and words) <input type="checkbox"/> Receptive language (e.g., understanding what others say) <input type="checkbox"/> Expressive language (e.g., express thoughts and feelings)		
<i>Describe any concerns you have about your child's language or speech skills.</i>		
<b>Has your child ever received language/speech therapy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next question) Explain: _____		
SOCIAL / EMOTIONAL / BEHAVIORAL		
<b>Indicate if your child has had any of the following difficulties:</b> <input type="checkbox"/> Difficulty making friends <input type="checkbox"/> Being a victim of teasing/bullying <input type="checkbox"/> Engaging in teasing/bullying behavior <input type="checkbox"/> Aggression/fighting <input type="checkbox"/> Anxious in groups of people <input type="checkbox"/> Fearful of speaking in social settings <input type="checkbox"/> Withdrawn or keeps to self <input type="checkbox"/> Inflexible/difficulty compromising <input type="checkbox"/> Insensitive to others' emotions/needs		
<i>Describe any concerns you have about your child's ability to get along with peers.</i>		
<b>Indicate if your child has had any of the following difficulties:</b> <input type="checkbox"/> Extremely fearful or nervous <input type="checkbox"/> Cries easily or whines frequently <input type="checkbox"/> Frequently complains of aches/pains <input type="checkbox"/> Depressed or very unhappy <input type="checkbox"/> Easily frustrated <input type="checkbox"/> Explosive/angry outbursts <input type="checkbox"/> Self-injurious (e.g., cutting) <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Obsessive/compulsive behaviors		
<i>Describe any concerns you have about your child's emotional functioning.</i>		

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**Has your child ever received counseling services?**    Yes    No (skip to next question)

Explain: \_\_\_\_\_

**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"/> Stealing or lying  | <input type="checkbox"/> Gang involvement   | <input type="checkbox"/> Defiance/oppositional behavior    |
| <input type="checkbox"/> Drug/alcohol abuse | <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Destructive behavior/starts fires |

**Has your child:**

- skipped school repeatedly or had a truancy officer contacted to address lack of school attendance
- been suspended from school [*indicate the reason for each suspension and the total days of each suspension*]
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
- been expelled from school [*indicate the reason for expulsion and the amount days of expulsion*]
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
  - reason: \_\_\_\_\_ days: \_\_\_\_\_
  - reason: \_\_\_\_\_ days: \_\_\_\_\_

*Describe any concerns you have about your child's 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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