Developmental History (Ages 10 – 21)

The *Developmental History* (Ages 10 – 21) is used to document a parent or guardian's concerns for their child and information about their child's overall development and functioning. It should be used to identify concerns that should be examined in depth by the Multidisciplinary Evaluation Team (MET). The *Developmental History (Ages 10 – 21),* or a similar form containing the same information, should be used when considering eligibility under any category, especially for children ages ten (10) to twenty-one (21) years of age.

1. The *Developmental History (Ages 10 – 21)* should be completed as part of a **structured interview** with the child's parent or guardian. Most parents/guardians will not be able to complete all areas of the *Developmental History (Ages 10 – 21)* without adequate guidance and explanations.

2. The child's parent or guardian should be encouraged—but not required—to answer all of the questions included on the *Developmental History (Ages 10 – 21)*. Make sure parents or guardians are aware that they are not required to answer any questions they do not wish to answer or feel uncomfortable answering.

3. The *Developmental History (Ages 10 – 21)* should document any concerns of the parent or guardian.

4. If the parent or guardian does not speak English, a translator should be provided to assist with the collection of this information.

5. The person conducting the structured interview should record her/his name and the date the interview was conducted at the end of the form.

GREENVILLE PUBLIC SCHOOL DISTRICT • OFFICE OF SPECIAL EDUCATION

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.

Informant:	Relationship to the Child:

PERSONAL DATA

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

HOME AND FAMILY INFORMATION

Parent(s)/Guardian(s):	Age:
Home Address:	Home Phone:
Employer/Occupation:	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 (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.).

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)
☐ 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
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
☐ Problems with hearing only ☐ Problems with vision only ☐ Problems with hearing and vision
Hearing difficulties: _____
Vision difficulties: _____

Does your child require devices to assist with hearing or vision? ☐ Yes ☐ No (skip to next question)
☐ Hearing aids (when acquired:_____) ☐ Glasses (when acquired:_____)

Physical Functioning

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

EDUCATIONAL / COGNITIVE

Can your child follow multi-step directions? ☐ Yes ☐ No (skip to next question)

Does your child regularly need:

☐ significant help with homework ☐ afterschool tutoring ☐ significant help organizing their school work
☐ follow-up to ensure s/he completes homework ☐ instructions or directions to be repeated or explained

Indicate any areas that your child has difficulties with:

☐ Getting along with teachers ☐ Basic math calculations ☐ Reading aloud, pronouncing words
☐ Planning ahead/solving problems ☐ Figuring money, time, etc. ☐ Understanding what s/he reads
☐ Other: _____
☐ Other: _____

Describe any difficulties your child has with thinking or learning activities.

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

By whom: _____ When: _____
Results: _____

ADAPTIVE

Does your child independently:

☐ Groom his/herself appropriately ☐ Run errands for the family ☐ Take care of his/her possessions
☐ Complete chores at home ☐ Handle money/make change ☐ Take care of younger siblings or relatives

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

COMMUNICATION

Indicate any areas that your child has difficulties with:

☐ Articulation (e.g., pronouncing sounds and words) ☐ Receptive language (e.g., understanding what others say)
☐ Expressive language (e.g., express thoughts and feelings)

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

Has your child ever received language/speech therapy? ☐ Yes ☐ No (skip to next question)

Explain: _____

SOCIAL / EMOTIONAL / BEHAVIORAL

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

☐ Difficulty making friends ☐ Being a victim of teasing/bullying ☐ Engaging in teasing/bullying behavior
☐ Aggression/fighting ☐ Anxious in groups of people ☐ Fearful of speaking in social settings
☐ Withdrawn or keeps to self ☐ Inflexible/difficulty compromising ☐ Insensitive to others' emotions/needs

Describe any concerns you have about your child's ability to get along with peers.

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

☐ Extremely fearful or nervous ☐ Cries easily or whines frequently ☐ Frequently complains of aches/pains
☐ Depressed or very unhappy ☐ Easily frustrated ☐ Explosive/angry outbursts
☐ Self-injurious (e.g., cutting) ☐ Suicidal thoughts ☐ Obsessive/compulsive behaviors

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

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?	☐ 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:

☐ Stealing or lying	☐ Gang involvement	☐ Defiance/oppositional behavior
☐ Drug/alcohol abuse	☐ Cruelty to animals	☐ 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: _____
- 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**

Report of Physical Observation

PERSONAL DATA			
Child's Name:	**Race/Ethnicity:**	**Gender:**	**DOB:**
District/School:	**MSIS #:**	**Grade:**	**Age:**

IMPAIRMENTS OR INJURIES

Describe any congenital or acquired impairment(s) in the child's general physical condition, fine and gross motor skills, hearing, vision, orofacial functioning, and/or physical/health problems (e.g., allergies, diabetes, asthma) or any injuries that impact cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-solving, sensory, perceptual and motor abilities, psychosocial behavior, physical functions, information processing, and/or speech, if any.

MEDICATIONS

List any medications that have been prescribed for the child, dosages, and potential side effects, particularly any that may impact classroom performance and/or educational testing.

LIMITATIONS AND PRECAUTIONS

Describe any limitations or precautions to consider when planning educational services, such as restrictions on mobility, activity, speech, equipment/adaptations, etc.

RECOMMENDATIONS FOR SCHOOL-BASED SERVICES

Describe any recommendations to consider when planning educational services, such as adaptive physical education, physical therapy, occupational therapy, speech/language therapy, mobility training, functional/self-care education, etc.

Healthcare Provider Specialty: _____

Signature: _____ **Date:** _____