2025-2026 Structured Development History (SDH)

Your input is important and appreciated. Please complete this form within **three school days**. We recommend setting aside **30 minutes of uninterrupted time** to ensure thoughtful and thorough responses. When asked to rate the student's behavior, please do so in comparison to **same-age peers**. When prompted for additional information, feel free to include as much detail as you feel is necessary to help us better understand the student's needs. Once finished, please click **"Submit"** at the end of the survey. If you have any questions or need assistance, you may contact me at (281) 634-3771 or by email at carol.clayborne@fortbendisd.com. Thank you for your support and collaboration in helping us better serve our students.
Sincerely,

Carol Clayborne Porter
Licensed Specialist in School Psychology

* Required

General Information

1. Parent / Guardian (Your) Name *

2. Parent / Guardian (Your) Email *

3. What is the best phone number where you can be reached? *

4. Student's First Name *

5. Student Last Name *

6. Student Number

7. Student's Current Grade *

- ◯ K
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10
- ◯ 11
- ◯ 12

8. What is the primary language of the home? (What language is spoken more than half of the time at home?) *

Physical

9. If your child's mother was not in good health during pregnancy, please explain below. Otherwise, please type N/A. *

10. If your child's mother was under any emotional pressure during the pregnancy and unable to care for him/her, please explain below. Otherwise, please type N/A. *

11. If your child was delivered via C-section, or if there were any other complications with delivery, please explain below. Otherwise, please type N/A. *

12. How much did your child weigh when he/she was born? *

13. If your child was hospitalized after delivery, please explain below. Otherwise, please type N/A. *

14. As an infant or toddler, was your child ever hospitalized? As an infant or toddler did your child have any head injuries, surgeries, or anything unusual or abnormal during early development? If so, please explain below. Otherwise, please type N/A. *

15. How would you describe your child's health during his/her first year? *

16. Who was primarily responsible for care of your child during early infancy? *

17. If your child had sleeping problems in early childhood, please explain below. Otherwise, please type N/A. *

Developmental Milestones

The following questions address when your child met developmental milestones. If you need additional information on developmental milestones, click the link below.

https://www.cdc.gov/ncbddd/actearly/pdf/checklists/Checklists-with-Tips_Reader_508.pdf

18. How old was your child when he/she began sitting alone? If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

19. How old was your child when he/she began standing alone? If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

20. How old was your child when he/she began walking without assistance? If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

21. How old was your child when he/she began talking? If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

22. How old was your child when he/she was toilet trained? If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

General Current Health

Please answer the questions below based on how your child's health starting after early childhood to now.

23. If your child ever had any childhood diseases, or ever had a high fever, please explain below. If you are not sure, please take your best guess. If you are not comfortable with giving an estimate, please type Not Sure. *

24. Regarding your child at present, how would you describe his/her health? *

25. Has your child had any illnesses, accidents, or surgeries? If so, please explain below. Otherwise, please type N/A. *

26. Has your child had any sleeping problems, eating problems, or unusual fears? If so, please explain below. Otherwise, please type N/A. *

27. How would you describe your child's emotional health? *

28. If your child is currently taking any medication, please type the name of the medication, the dosage amount if you know it, and what it was prescribed for, and low long your child has been taking the medication. Please include all medications currently being taken. *

29. Please provide information on your child's vision. Does your son/daughter currently need glasses? If so, do they have glasses with a current prescription, or is the prescription old? *

30. Please provide information on your child's hearing. Does your son/daughter currently need a hearing aid? If so, do they have one with a current prescription, or is the prescription old? *

31. When was your child's most recent doctor visit? What did he/she see the physician for? Please explain below. *

32. Please provide the name and contact information for your child's doctor below. If you do not have this information, please type N/A. *

33. If there is a family history of mental retardation, learning, or behavior problems within the family please explain below. Otherwise, please type N/A. *

Example: My child's father has Dyslexia.

Sociological

34. What are the names and ages of all those currently living in the same household as your child? *

35. How long has your child been living in his/her this current arrangement? *

36. What is the name of your child's guardian(s)? What is their educational background? *

37. Where are your child's guardians currently employed? Was the household employment situation affected by COVID-19? Please explain below. *

38. Have there been any significant changes or trauma in the household in the last 3 years? Please explain below. Otherwise, please type N/A. *

EMOTION / BEHAVIOR

39. When not in school what does your child enjoy doing with the family / by him or herself? *

40. What behavior do you usually have to correct your child for? How do you correct him/her? How does he/she respond to the correction? Please explain below. *

41. How does your child feel about school? Please elaborate below. *

42. What are your child's strengths / weaknesses? *

43. AREAS OF CONCERN: *

Please mark all that apply

- [ ] frequent absences
- [ ] limited verbalizations
- [ ] problems focusing and maintaining attention
- [ ] low frustration tolerance
- [ ] physical restlessness / impulsivity
- [ ] difficulty following classroom rules
- [ ] immature social skills
- [ ] limited memory / retention
- [ ] inconsistent motivation / drive
- [ ] disorganized work habits
- [ ] poor task completion
- [ ] limited self-confidence
- [ ] variable performance
- [ ] difficulty working independently
- [ ] poor motor planning
- [ ] difficulty copying from board
- [ ] Other

44. Please describe / elaborate on selected areas of concern. Otherwise type N/A. *

45. ATTITUDE *

Please select all that apply

- [ ] good attitude / behavior
- [ ] poor attitude / behavior
- [ ] lack of effort
- [ ] lack of / poor participation
- [ ] not attentive to instruction
- [ ] uncooperative
- [ ] Other

46. Please elaborate on any selected items from above *

47. CONDUCT *

Select one

- ◯ Your child's behavior in the home is not a problem at this time.
- ◯ Your child's behavior in the home is currently disruptive at home / unacceptable behavior.

48. If your child is currently seeing a mental health professional outside of the home, may we contact them in order to add their input to your child's profile? If so, please leave their name, business name, address, and phone number below. You will receive a notice of consent to sign that will allow FBISD Special Education staff to contact your child's mental health provider. *

49. SUMMARY *

In the space below please give a brief summary statement on the scholastic progress, and conduct of the student listed above with respect to their IEP goals in addition to any other information you believe important.

COGNITIVE

50. Please place a check mark nest to those activities your child can complete by himself/herself.

- [ ] Complete chores around the home.
- [ ] Recite their home address.
- [ ] Recite their home phone number when asked.
- [ ] Walk alone to a friend's house who lives close by.
- [ ] Tell time
- [ ] Identify coins and their value.
- [ ] Make small purchases at the local convenience store with/without correct change.
- [ ] Cook simple meals.
- [ ] Clean his/her room.
- [ ] Use the clothes washer and dryer.

51. Please explain any responses you indicate above in the space below. *

52. What are your primary concerns for your child's cognitive development? What are your child's strengths? *

Definition of cognitive 1: of, relating to, being, or involving conscious intellectual activity (such as thinking, reasoning, or remembering)

ACADEMIC

Definition of academic
of or relating to performance in courses of study academic excellence or academic achievements

53. Do you have any concerns with regard to your child's academic performance? (How well they are making progress in their classes at school.)

54. Please leave a day/time/phone number when you can be contacted if any questions regarding your responses arise. Thank you for completing this form. *