CHILDHOOD HISTORY AND INFORMATION

Name of Child____ Date of Birth____________________

Address____Phone #______________________

FAMILY AND SOCIAL HISTORY

Mother (or guardian)____Age_____________

Father (or guardian)____Age_____________

Marital Status of Parents:
Living Together__________ Stepfather______________ (How Long)
Separated______________ (How Long) Stepmother_____________ (How Long)
Divorced______________ (How Long) Remarks____

If Child is Adopted:
Age at Adoption________________________
Does child know about adoption____________

Custody/Visiting Arrangements____

____

Brothers and Sisters of Child:

Name___________________________________ Age________ Grade in School______ Lives in Home? _______

Name___________________________________ Age________ Grade in School______ Lives in Home? _______

Name___________________________________ Age________ Grade in School______ Lives in Home? _______

Any other members of household (include relationship and age): ______________________________________

____

Who has cared for your child other than you?____

____

Has your child had group play experience? If yes, where? ____

____

SLEEPING HABITS

Does your child sleep in the same room with anyone else?__________ Does your child nap?________

If so, for how long? _______________If your child can't sleep, do you require a rest period?__________

If so, how long?_______________ Are there any habits associated with napping?___________________

If so, please specify____

DEVELOPMENTAL HISTORY

Personal: Circle your description of your child:

a. active	average	quiet
b. thin	average	heavy
c. tall	average	short
d. friendly	average	shy

At what age did your child do the following:
Sitting____________ Crawling____________ Walking____________ Talking____________

Any difficulties with the following:
❒ special fears (be specific)____
❒ large motor activities (walking, running, etc.) ❒ small motor activities (picking up objects, etc.)
❒ language ❒ hearing ❒ sight/vision ❒ any other special needs (be specific)

____

Eating:
Is your child usually hungry at mealtime?___________________ Between meals?____________________

What are your child's favorite foods?____

Least favorite foods?____

Does your child feed himself/herself? ________________ Use a spoon?____________ Use hands?____________

If your child refuses to eat, how do you handle it?_________________________________

Is your child allergic to any foods?____

Toileting:
Does your child take himself/herself to the bathroom?_______________________________

Does your child tell you when he/she needs to go?____________ Any special words used:_____________________

____

Health:
What arrangements can you make for your child's care during illness?___________________________

____

Allergies (other than food)?____

Does your child frequently have any of the following:
❒ colds ❒ ear infections ❒ seasonal allergies ❒ sore throats ❒ other (Be Specific)

____

Medications regularly taken?____________ If yes, please list name and what it is taken for: ___________________

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Additional Comments or Information Provider Should Know:

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