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Developmental History

Child's Name: _____ **Date of Birth**: _____

Is your child adopted? Yes ☐ No ☐ If yes, at what age? _____

Does your child attend another school? Yes ☐ No ☐ If yes, where and how many days a week?

_____

Developmental History

Age child began sitting _____ crawling _____ walking _____ talking _____

Does your child use special words to describe needs? _____

Does your child use a pacifier or suck thumb? _____ When? _____

What language(s) is/are spoken at home? _____

Any speech difficulties? _____

Any motor development difficulties? _____

Any other developmental concerns at this time? _____

Does your child receive Early Intervention or supportive services? Yes ☐ No ☐

If yes, describe: _____

Health History

Any known complications at birth? _____

Serious illnesses and/or hospitalizations? _____

Special physical conditions, disabilities? _____

Any allergies? i.e. asthma, hay fever, insect bites, medicine, food reactions: Yes ☐ No ☐

If yes, describe: _____

Are any medications given regularly to your child? Yes ☐ No ☐

If yes, what and why? _____

Eating Habits

Special characteristics or difficulties: _____

Favorite foods: _____

Foods refused: _____

What does your child use to eat with? _____ Does your child drink from a cup? _____

Please complete both sides

Toilet Habits

* Does your child wear diapers? Yes ☐ No ☐

Is there a frequent occurrence of diaper rash? _____

* What products do you use to treat rash? _____

* Is your child working on becoming toilet trained? _____

How does your child indicate bathroom needs? _____

Is your child reluctant to use the bathroom at home? Yes ☐ No ☐

Outside of home? Yes ☐ No ☐

Does your child have bathroom accidents? Yes ☐ No ☐

Sleeping Habits

Does your child take a nap during the day? Yes ☐ No ☐

If yes, when and how long? _____

At what time does your child go to bed at night? _____ and get up in the morning? _____

Social Relationships

How would you describe your child?

_____

_____

What does your child do when he/she is not at school? _____

_____

Does your child have any experience playing with other children? _____

How does your child relate to strangers? _____

Does your child play well alone? _____

What is your child's favorite toy/activity? _____

Does your child have any fears (storms, animals, etc.)? _____

How do you comfort your child? _____

What is the method of behavior management/discipline at home? _____

_____

Is there anything else we should know about your child?

_____

_____

Parent/Guardian Signature: _____ Date: _____