

Name _____ Date _____

Development History

Health

*What past illnesses has your child had? At what age?

Chicken pox _____ Scarlet fever _____
Diabetes _____ Mumps _____ Measles _____
German measles (3 days) _____ Hepatitis _____
Tonsillitis _____ Strep throat _____ Earache _____
Stomach/Abdominal problems _____
Others _____

*Does child have frequent colds? Explain _____

*Does child run high fevers easily? _____

*How does child react to an elevated body temperature? _____

*Has child ever had convulsions due to high fever? Explain _____

*Has child ever had surgery? Explain _____

*Has child ever had a serious accident, illness or hospitalization? _____

*Is your child allergic? _____ If so, how does it manifest itself? _____

Asthma _____ Hay fever _____ Hives _____

Rash _____ Fever _____ Others _____

*What causes allergy attack? _____

*Does your child take medication for allergies? _____

*Does child have food allergies? Explain _____

Toileting

*Can child relate bathroom wishes? _____ * Word used for
urination? _____ bowel movement _____

*Does child need relief more frequently than usual? _____
how does child react _____

*Does child need help with toileting? _____

Sleeping

*What time does child go to bed? _____ awoken _____
*Is child read for sleep at night? _____
*Does child have own room? _____ own bed _____
*Is child frequent bed-wetter? _____ *Does child walk, talk or cry out at night?
_____ *What is child's mood in the morning?

*Does child need nap? _____ what time (s) _____

Social Relationships

*Is child right or left-handed? _____ *Does child dress self? _____
undress self _____ *Is this first separation from home? _____
*Has child had experience in playing with other children? _____
*By nature, is child friendly? _____ aggressive _____
shy _____ *How does child get along with siblings? _____
_____ other adults _____
*Does child know any children in this day care? _____
*Do you feel child will adjust easily to a day care environment? _____
_____ *Does child enjoy
being alone? _____ *How does child react to strangers? _____

*Does child have any physical disabilities? _____
*Has child had vision tested? _____ Hearing _____
*Does child wear corrective lens? _____ *Please give statement of child's overall
health _____

Personal History

*Age child began to sit alone _____ crawl _____
walk _____ *Is child a good climber? _____
*Does child fall easily? _____ *Age child began to speak in
words _____ in sentences _____
*Does child have difficulties in speech? _____
*Are there other languages spoken in the home? _____

Eating

*Is child usually hungry at mealtime? _____ Between _____
meals _____ *Is child use to having between meal snacks?
_____ *Foods refused _____

*Favorite foods _____

*Are there eating problems? _____

*Does child eat with a spoon? _____ a fork _____
hands _____

*What time does child eat breakfast? _____ lunch _____
supper _____ *Is child a vegetarian? _____

*Dietary restrictions _____

*Does child demand a lot of attention? _____ *What angers/upsets child?

*What do you find is the best way of handling child when upset/angry? _____

*What is child's reaction to discipline? _____

*Does child have any special fears? _____

*Does child like to be read too? _____ listen to music _____
*Does child prefer outdoor play? _____

*What is favorite outdoor activities? _____

*What is favorite indoor activities? _____

*Who cares for child other than parents? _____

*Describe your child briefly (physical appearance, personality abilities, etc.) _____

*In what particular way(s) can we help your child this year? _____

*Additional comments, concerns, information we'll need to know? _____