

Developmental History

Christ Church Children's Center

Child's Last Name: _____

Child's First Name: _____

Date of Birth: ____/____/____

School Year: _____

PERSONAL HISTORY:

Age began sitting _____ crawling _____ walking _____ talking _____

Any difficulties in speaking _____ Other language spoken _____

Special words to describe needs _____

HEALTH:

Any complications at birth? _____

Any serious illness or hospitalization? _____

Any physical conditions, disabilities? _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Any medications given regularly? _____

EATING:

Are there any characteristics or difficulties with eating? _____

Favorite foods _____ foods refused _____

Does child eat with spoon ___ fork ___ hands ___?

TOILET HABITS:

How does child indicate their bathroom needs? _____ word for urination _____

Word for bowel movement _____

Is your child reluctant to use the bathroom? _____ Does your child have accidents? _____

SLEEPING HABITS:

Does child take naps? _____ From when _____ to _____? What time does child go to bed in the

PM _____ Awaken in the AM _____? Mood on awakening _____

Describe any special characteristics or needs of your child at bedtime _____

Please describe your child's schedule on a typical day: _____

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SOCIAL RELATIONSHIPS:

How would you describe your child? _____

Previous experience with other children /day care/ early intervention/ playgroups? _____

By nature is child friendly? _____ shy? _____ aggressive? _____ passive? _____ withdrawn? _____
serious? _____ silly? _____ other? _____

How does child relate to new adults? _____ new children? _____

Does child play well alone? _____

What is your child's favorite activity? _____

What is child's favorite toy? _____

Fears (the dark, animals, loud noises, etc.) _____

How does your child respond to frustration? _____

How do you comfort your child?: _____

How do you discipline your child? _____

Who does most of the disciplining? _____

What is the best way of handling your child? _____

How does your child respond? _____

What would you like your child to gain from the preschool experience? _____

Is there anything else you would like us to know about your child? Please let us know if your child has been receiving speech therapy, or has any special needs that should be taken into account when planning class placement. _____

Parent's Signature: _____

Date: ____/____/____