

CHILD DEVELOPMENT HISTORY

Child's Name: _____ DOB: _____

CHILD DEVELOPMENT HISTORY SHEET

Center _____

Admission Date _____

Parent's Name _____

Telephone Number _____

Emergency Person _____ Telephone Number _____

Early History:

Verification of Birth (e.g. birth certificate) _____

Weight at Birth _____ Type of Feeding _____

Gestation:

Length of Pregnancy Full Term _____ if not, how many weeks _____

How was Pregnancy and Delivery Normal _____ C-section _____ Other _____

Age of:
Weaning _____ Walking _____ Talking _____ Toileting _____

Special Note _____

Health:

Any outstanding health concerns about your child _____

Eating:

Favorite Foods _____

Allergies _____

Appetite: Good _____ Fair _____ Poor _____ Irregular _____

Feeds Self _____ Uses Fork _____ Uses Spoon _____ Bottle _____ Cup _____

Sleeping:

Does child nap? _____ How long? _____ Irregularly? _____

Sleeps alone in bed? _____ In room with _____

Dressing:

Can the child dress him/herself? _____ Tie shoes? _____

Toileting:

Is the child toilet trained? _____ Does the child have accidents? _____

Speech:

What language does the child speak? _____

Discipline:

How do you get your child to do what you ask? _____

Does your child listen to authority figures? _____

What is your child afraid of? _____

Does your child have tantrums? _____ If yes, what are they like? _____

Special Development:

What terms do you use for urination? _____ Bowel Movement? _____

Describe Relationship with:

Mother _____

Father _____

Siblings _____

Peers (shares, fights, etc.) _____

Special Friends _____

Special Notes

Has the child been separated from parents during the day? _____

Who cares for the child now? _____

What type of toys does the child like? _____

Does the child watch T.V.? _____ If yes, what shows? _____

Other activities _____

Habits:

Does your child bite nails? _____ Sucks thumb? _____ Other _____

Describe child's personality (outgoing, nervous, aggressive, etc.) _____

What upsets your child? _____

What do you do to make your child feel better? _____

Has your child ever received services under any of the following:

Early Intervention _____ Pre-School Special Education _____ Other _____

If yes, please check all the services received:

Speech ___ Occupational ___ Physical ___ Instructional ___ Other ___

What are your medical concerns if any? _____

At this time is there anything else you would like us to do know about your child? _____