Developmental History

Child's Name _____ Date of birth _____

Nickname _____

Family History:
Mother's name (or guardian) _____ Father's name (or guardian) _____
_____ single _____ married _____ separated _____ divorced _____ remarried

Custody/visiting arrangements_____

Is child involved in a step-family? Yes or No How long?_____

If child is adopted, does child know?_____

Brothers & Sisters:
Name _____ Date of birth _____ Grade _____

Name _____ Date of birth _____ Grade _____

Name _____ Date of birth _____ Grade _____

Other members of household (include relationship & age) _____

_____
What is child's reaction when separated from parent? _____

_____
What method of behavior control is used in your home? _____

_____
What is the child's usual reaction?_____

Does child have fears which you are aware? Yes or No

If yes, please describe_____

Has the child experienced any periods of stress (deaths, separation, serious illness)? Yes or No

If yes, please describe _____
How would you describe your child's personality? _____
Does child show right or left handedness?_____ Unclear_____

Does your child have allergies? Food, Environmental or Allergies to Medicine (If so, please list normal reaction if exposed)

_____
_____
_____

Medical History

Please write age at which child acquired each illness.

Chicken pox____ Scarlet Fever____ Hepatitis____ Mumps____ Measles____ Diabetes____other _____

Does the child run unusually high fevers? _____

Does the child usually have seizures with a high fever? _____

Infancy Information

Was your pregnancy to term? _____ Child's Birth Weight _____ Length_____

Age at which child:
Crept on hands & knees _____ Sat alone _____ Walked alone _____
Named simple objects _____ Slept at night _____

Has child been in a day care atmosphere previously? _____

Diet Information

Is the child a vegetarian? Yes or No
Is child familiar with silverware? Yes or No
Are there any dietary restrictions? Yes or No
If yes, please describe _____

What are the child's favorite foods? _____

Sleep Habits

What time does child usually go to bed at night? _____ What time does he/she awaken? _____

Does the child sleep well? _____ What is the child's mood upon awakening? _____

Does the child take daily naps? Yes or No If yes, approximately at what time_____

Interactive Play

What are the child's favorite indoor activities? _____

Favorite outdoor activities? _____

Does the child have any pets? _____ What kind & names?_____

Does the child have neighborhood playmates?_____

Does child enjoy reading? ___ Favorite stories?_____

Please feel free to provide additional comments about your child.
_____
_____

Signature _____ Date_____

*If you would like to meet at any time to discuss any aspect of development, please contact your child's teacher or the office.

Child's Name:_____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

- ☐ I am providing a copy of my child's IEP or IFSP.
- ☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature:_____ **Date:**_____

Printed Name:_____