CHILD DEVELOPMENTAL HISTORY

Name of Child _____ Nickname: _____ Date of Birth _____

Date of Enrollment _____ Name of Parent/Guardian _____

HEALTH:

Does your child have any allergies? Yes ( ) No ( )

If so, what allergies does your child have? _____

How should we respond if he/she has an allergic reaction? _____

Does your child have any health conditions such as diabetes, heart condition, etc? Yes ( ) No ( )

Please describe any health conditions the child may have: _____

_____

Must your child's activities be limited because of health conditions? Yes ( ) No ( )

Please list any limitations to activities: _____

Is the child presently taking medications? Yes ( ) No ( )

If so, how is the medication administered, and will it need to be administered while he/she is in care?

_____

Is the medication prescribed for continuous use? Yes ( ) No ( )

Are there any side effects we should be alerted to? Yes ( ) No ( )

TOILETING

Does your child need assistance with toileting? Yes ( ) No ( )

How can we best help? _____

What are your ideas about toilet training? _____

How can we best help? _____

What words does the child use to indicate the need to go to the bathroom? _____

Does the child dress and undress by himself/herself? Yes ( ) No ( )

BEHAVIOR

Does the child have any specific fears? Yes ( ) No ( )

Please list and explain your child's fears: _____

Are there any particular routines that are particularly helpful at naptime? _____

What position is most comfortable for your child when he/she is napping? _____

Explain or check any of the following behaviors pertaining to your child that you are concerned about:

❒ Whining	❒ Fighting/hitting	❒ Awkwardness	❒ Requires excessive attention
❒ Shyness	❒ Thumb-sucking	❒ Nail-biting	
❒ Screaming	❒ Sensitiveness	❒ Depressed	❒ Excessively throwing tantrums
❒ Very excitable	❒ Bites self	❒ Withdrawn	
❒ Quarreling	❒ Irritability	❒ Nervous	❒ Rocks back and forth
❒ Bumps head	❒ Bites others	❒ Fearful	❒ Excessively active

Please explain about any behaviors checked: *(please use back for more explanations)* _____

_____

How do you tell your child to stop a behavior that your don't approve of or that might be dangerous? _____

When your child gets upset, what helps him/her calm down? _____

What is a good way to distract your child when he/she is having a temper tantrum? _____

Does the child play well with other children? Yes ( ) No ( )

Does the child prefer to play alone? Yes ( ) No ( )

What toys or games does your child prefer? _____

What activities does he/she prefer? (Include both indoor and outdoor activities).

_____

In your opinion, do you feel this child requires more attention and/or time than most children? Yes ( ) No ( )

If yes, explain: (Include how much extra time and what extra time is needed for) _____

DIET/NUTRITION

Is the child on a special diet? Yes ( ) No ( )

Please list the special diet: _____

List any foods that the child should not be allowed to eat for medical or other reasons. _____

What are your child's favorite foods? _____

Does your child use utensils, eat with fingers, and/or feed self? _____

Does your child choke easily while eating? Yes ( ) No ( )

Is the child able to feed himself/herself? Yes ( ) Some ( ) No ( )

Does the child have any difficulty: Sucking ( ) Chewing ( ) Swallowing ( )

Does the child drool? Yes ( ) No ( )

SPEECH/COMMUNICATION

Does your child understand spoken (verbal) communication? Yes ( ) No ( )

Does the child speak: English ( ) Spanish ( ) Other: ( ) _____

How much does the child speak? 75 - 100% ( ) 50 – 75% ( ) Less than 50% ( ) None ( )

How much of this speech can be understood? 75 - 100% ( ) 50 – 75% ( ) Less than 50% ( ) None ( )

Does the child use hand gestures or sign language to communicate? Yes ( ) No ( )

HEARING

Does your child wear a hearing aid? Yes ( ) No ( )

Does your child know how to replace it? Yes ( ) No ( )

List special instructions for removing, replacing, and/or operating the hearing aid? _____

VISION

Does your child wear glasses? Yes ( ) No ( )

Does your child receive specialized instruction? Yes ( ) No ( ) Not Applicable ( )

Please list the name(s) of the instructor, dates, and times of the specialized instruction: _____

Will instruction continue while in care at Greenwood Molina Children's Center? Yes ( ) No ( )

PHYSICAL

Does the child have any physical conditions/limitations? Yes ( ) No ( )

If so, describe the physical conditions/limitations (crawling, walking, moving, etc.) that your child may have:

_____

List adaptive equipment that the child wears and/or uses: _____

Does the child know how to operate or use this equipment without assistance? Yes ( ) No ( )

List special instructions for removal, use and operation of the adaptive equipment: _____

Our concern is the positive and smooth transition of your child into the Greenwood Molina Children's Center. Please assist us by making further suggestions/comments that might help your child adjust to his/her new environment.

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date