

Developmental History

Child's Name: _____ Date: _____

Physical Background

Does your child have any allergies? YES NO

If yes, please list: _____

Is your child taking any medications on a regular basis? YES NO

If yes, please list: _____

Is there anything from your child's health history that would be helpful to us?

(Preterm birth, asthma, heart conditions, injuries, etc.)

Do you have any developmental concerns (speech, etc) about your child? YES NO

Has your child had Early Childhood Screening from you local school district? YES NO

If yes, please provide reason for screening and date: _____

Which hand does your child use mainly? Right Left Undecided

Does your child still nap? YES NO

Social Background

Is this your child's first group experience? YES NO

Is there another caregiver in your child's life? _____

What indoor activities does your child enjoy? _____

What outdoor activities does your child enjoy? _____

Please turn Over

Does your child have play dates? YES NO

Ages of playmates: _____

How does your child get along with other children, siblings, etc.? _____

Emotional Background

Does your child have trouble separating from you or the caregiver? YES NO

If yes, please explain: _____

Are there any special behavior problems we should know about? YES NO

If yes, please explain: _____

What style of discipline works best with your child? _____

Are you aware of any fears or anxieties your child may have? YES NO

If yes, please explain: _____

Does your child find it easy or difficult to share possessions with others? YES NO

When upset, how is your child best comforted? _____

How does your child comfort his/herself when upset? _____

Please circle the self help skills your child can do by him/herself

Toilets alone washes hands puts on coat puts on shoes

Other: _____

Please list any other concerns you feel need to be addressed by the Preschool staff: _____
