Developmental History and Background Information

Child's Name _____ Date of Birth _____

Regulation for licensed childcare facilities require this information to be on file to address the needs of children while in care.

Developmental History

Age began: Sitting_____ Crawling_____ Walking_____ Talking: First words_____
Sentences_____

Did your child babble or make play noises during infancy: ☐Yes ☐No

Languages spoken at home: Primary_____ Other_____

Has your child demonstrated any difficulties or do you have any concerns about your child's development in *any* of these areas? _____Speech or Language _____Motor Skills _____Social Skills
_____Cognitive (intellectual) _____Sensory _____ Behavioral _____Emotional
Describe _____
Does your child use a pacifier or suck thumb?_____ When?_____
Does your child have a fussy time?_____ When?_____
How do you handle this time?_____

Health

Any known Complications at birth?_____
Serious illnesses and/or hospitalizations_____
Special physical conditions, disabilities_____
What allergies and the reaction does your child have? (if any) _____

_____
Regular medications: _____

Eating Habits

Was/is your child _____Bottle Feed name of formula_____ How long_____
_____Breast Feed How long_____
Special Characteristics, difficulties, or diet restrictions:_____

_____
If your infant is on a special formula, describe its preparation in detail and give us the name.

_____
Is your child fed held in lap?_____ High chair?_____
Does your child eat with a spoon?_____ Fork?_____ Hands?_____

Toilet Habits

Is your child toilet trained? ☐Yes ☐No ☐"in progress"
Concerns/Fears?_____

If no has toilet training been attempted? ☐Yes ☐No

Do they need to be reminded? ☐Yes How often _____ ☐No
What word does your child/family use for
*urination?*_____ *Bowel movement?*_____

Are disposable or cloth diapers used?_____Is there a frequent occurrence of diaper rash?☐Yes ☐No

Are bowel movements regular?☐Yes ☐No How many per day?_____

Is there a problem with diarrhea?☐Yes ☐No Constipation?☐Yes ☐No
Please describe any particular procedure to be used for your child at the center_____

_____
What is used at home? Potty chair?_____ Special child seat?_____ Regular seat?
How does your child indicate bathroom needs? include special words)_____

Is your child ever reluctant to use the bathroom? ☐Yes ☐No Does your child have accidents? ☐Yes ☐No

Sleeping Habits

Describe your child's sleeping arrangements: ☐Family bed ☐Own bed ☐Crib ☐other_____

Does your child sleep on their ☐Back ☐Stomach ☐Side

Does your child go to sleep ☐Easily ☐With difficulty ☐With a bottle ☐With a parent ☐Use a comfort item

Does your child have a bed time ritual? ☐Yes ☐No Describe_____

_____

Does your child have a regular bed time? ☐Yes ☐No Goes to bed at_____ Wakes at_____

Does your child nap? ☐Yes ☐No For how long?_____ What time of day?_____

What is your child's mood upon awakening? _____

Please note: The American Academy of Pediatrics has determed that placing ababy on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden andunexplained death of a baby under one year of age. If your child does not usuallt sleep on his/her back , please contact your pediatrician immediately to discuss the best sleepinf potion for yourbaby. Please also take the time to disscuss your child's sleeping postion with your caregiver.

Activities and Play

Does your child *avoid* any physical activities? ☐Yes ☐No

Describe_____

Does your child attend any regular groups or classes? ☐Yes ☐No

Describe_____

Does your child demand a lot of adult attention? ☐Yes ☐No

Social Relationships

Does your child usually play ☐alone ☐w/siblings ☐w/peers ☐w/younger children ☐w/older children ☐w/adults?

How would you describe your child?_____

_____

Previous experience with other children/childcare_____

_____

Reaction to strangers_____

Able to play alone_____

Favorite toys and activities_____

Fears (dark, animals, etc)_____

What is the name of your child's comfort item? _____

How do you comfort your child?_____

What is the method of behavior management/discipline at home?_____

_____

_____

Daily Schedule

Please describe your child's schedule on a typical day. Please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc._____

_____

_____

_____

Other Information

Does your child have any developmental delays or special needs? ☐Yes ☐No Explain_____

Has your child had a developmental or diagnostic assessment? ☐Yes ☐No Explain_____

Does your child receive any services (Speech, O.T., etc.) ?☐Yes ☐No Explain_____