



Developmental History Form

Parents have a lot to teach us. Your “insider” perspective on your child will help staff better respond to your child’s needs. Please fill out this form with as much information as you can.

Child’s Name: _____ **DOB:** _____

Names and ages of siblings (or step-siblings) living with your child:

Who lives in the home? _____

Are there pets in the home? If so, please specify:

Are there religious or family/cultural traditions your child observes? If yes, describe:

DEVELOPMENTAL HISTORY

Age began sitting: ___ crawling: ___ walking: ___ talking: ___

Any speech difficulties? _____

Language spoken at home _____ Any history of colic? ___

Does your child use pacifier or suck thumb? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations? _____

Special physical conditions, disabilities? _____

Does your child have an IEP? _____ (If yes, we need a copy on file)

EATING HABITS

Favorite foods: _____

Foods refuses: _____

Is your child fed in your lap, at the table, in a high chair, allowed to walk around?

TOILET HABITS

Are disposable or cloth diapers used? ____ Does your child frequently get diaper rashes?
_____ If yes, what usually helps most: _____

Are bowel movements regular? _____ How many per day? _____

Is there a problem with diarrhea? _____ Constipation? _____

Has toilet training been attempted? _____

Please describe any particular procedure to be used for your child at the center:

What is used at home? Potty chair? __ Regular seat? __ Special seat? __

How does your child indicate bathroom needs: _____

Does your child have accidents? _____

SLEEPING HABITS

Does your child sleep in a crib? ____ Co-sleep? ____ Bed? ____

When does your child go to bed at night? _____ Get up? _____

Describe any special sleeping needs: _____

How do you get your child to go to sleep? _____

SOCIAL RELATIONSHIPS

How would you describe your child's personality?

Previous experience with other children/day care:

Likes to play alone? _____ With other children? _____

Favorite toys: _____

How do you comfort your child? _____

What triggers a temper tantrum or aggression, such as biting?

How do you de-escalate a tantrum? _____

What is your method of behavior management at home?

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Does your child have fears we should know of? If yes, specify and provide tips for helping your child cope with them.

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What would you like your child to gain from this child care experience?

Anything else you want us to be aware of?

Parent Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Lead Teacher's Signature: _____ Date: _____