Covesville Child Development Center

Developmental History

Child's Name: _____ Date _____
Last First Middle

BACKGROUND

Birth was: a) Premature _____ b) Timely ___ c) Late ____

Any complications? If so, please describe: _____
_____
_____

Previous Child Day Care Programs and Schools Attended_____
_____

Your child's position in the family: ____oldest ____ middle ____ youngest ____ only child
Was your child adopted? _____ If so, is (s)he aware of the adoption? _____

EATING

If your child is now younger than 2, describe what (s)he eats/drinks and the feeding schedule:
_____
_____
_____

Is your child usually hungry at mealtime? _____ Between meals? _____
What are your child's favorite foods? _____
What foods does your child not eat? _____
Any food allergies? _____
How are meals eaten at home? _____
What, if any, eating problems does your child have? _____

TOILETING (if applicable)

Who did/will toilet-train your child? _____ At what age was your child toilet trained? _____
Was toilet training easy or difficult? _____ Is your child fully toilet-trained now? _____
Does your child have some accidents? _____ How does your child react to "accidents"? _____

Does your child need help with toileting? _____
Does your child wet the bed at night? _____ At naptime? _____

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Does bed-wetting occur occasionally or regularly? _____

What word do you use for urination? _____ For bowel movements? _____

SLEEPING

What time does your child go to bed? _____ What time does your child wake up? _____

If you awaken your child, what time do you do this? _____

What is your child's bedtime routine? _____

Does your child take naps? _____ From when to when? _____

HEALTH

Has your child had any serious illness or ever been hospitalized? _____ If yes, please describe: _____

_____

What allergies does your child have (asthma, hay fever, insect bites, medicines, etc.)? _____

_____

How does your child react to high temperature? _____

Do you have any special instructions if your child becomes ill? _____

_____

Has your child taken Tylenol/Advil successfully? _____

Are there any medications given regularly? _____What? _____

PERSONAL HISTORY

Briefly describe your child (e.g., personality, abilities, concerns you may have): _____

_____

_____

Describe your child's favorite activities when alone. _____

Describe your child's favorite activities with adult(s). _____

Describe what your child likes to do with other children. _____

Describe your child's experiences playing with other children. _____

_____

By nature your child is:

_____friendly _____ aggressive

_____shy _____withdrawn

_____calm _____easily excited

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Does your child know any children at the Center? _____ who? _____
What makes your child angry or upset? _____
How does your child express these feelings? _____
How does your child express other feelings? _____
What do you find is the best way of handling your child? _____
_____

Is your child frightened by any of the following?

Animals _____ loud noises_____ small spaces_____
Dark _____ storms_____ rough children_____
Any other fears or worries? _____

Which of the following does your child like?

books _____ music_____
art_____ playing outdoors_____
pretending_____ puzzles_____
blocks_____ water_____

On average, how much time does your child spend watching TV each day? _____

What programs does your child like to watch? _____
_____

In what particular ways can we help your child? _____
_____
_____

In what ways could the Center help you (e.g., parenting classes, parent-teacher conferences, speakers/discussions relating to specific problem areas, etc.)?
_____
_____
_____
_____

Date_____

Signature_____

Signature_____