



Developmental History Form

Date form was completed: _____

General Information

Child's Name: _____

Date of Birth: _____

Nickname(if any): _____

Date of Enrollment: _____

Days child will attend center: _____

Hours: _____

Who will typically drop off your child? _____

Who will pick up your child? _____

Marital Status: Married Divorced Separated Single

Is there other information about your family that you feel is important to us to be aware of (examples: adoption, foster care, sharing of guardianship, custody or visitation schedules,etc.)?

Have there been any major changes within the family (examples: new sibling, divorce, death in family, moved to new apartment)?

List any prior child care experiences your child has:

Pregnancy and Delivery History

Were there any health complications during pregnancy with this child that our Nurse Consultant should be made aware of (Diabetes, Toxemia, etc.)? Please describe:

Was your child born prematurely? _____ If yes, how premature? _____

If you know, please include how much did your child weigh at birth _____

Were there any problems during the first weeks at home (nursing, weight loss, etc.)? If yes, please describe:

Does your child have known developmental delays or do you have concerns about your child's development to this point? If yes, please describe:

Has your child ever received Birth to Three services? _____

Does your child have an IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan)? Please share details here and include a copy of your child's IFSP and/or IEP to the program upon enrollment.

Feeding/Eating Habits

Does your child have dietary restrictions or special diet? _____

Please tell us more about this: _____

Does your child have any food allergies or foods they are unable to eat? _____

Please tell us more about this: _____

*****For infants enrolled at the Center:**

Breast Milk only

Breastmilk and Formula

Formula only

Usual Schedule and Amount:

Name of Formula (if applicable) _____

Holds Own Bottle _____

Uses a Training Cup _____

What solid foods is your infant currently eating:

____ Fruits ____ Juices ____ Vegetables ____ Cereals ____ Meats ____ Milk

*****For Toddlers and Preschoolers:**

Is/Was your child: Breast fed _____

Bottle fed _____

Does your toddler/preschooler drink from:

____ a bottle (if yes, when? _____) ____ a training cup ____ a regular cup

Can your child eat independently? ____ with fingers ____ spoon ____ fork

Food Likes _____

Food Dislikes _____

Toilet Habits

Does your child indicate their bathroom needs? _____

In order to support your child, it's helpful for us to know the words your child and family uses for urination, bowel movements, genital areas.

Is your child frightened of the bathroom? _____

Does your child use a potty seat at home? _____

Sleeping Habits

Where does your child sleep? _____

If your child naps at home can you share for how long and what time of day? _____

Does your child prefer to sleep on their: _____stomach _____back _____side

***We comply with the Office of Early Childhood's safe sleep policies for children under 1 year old.

Do you have any special ways of helping your child go to sleep (toys, back rub, etc.)? _____

Does your child usually cry when going to sleep? _____ If yes, how long? _____

Does your child use a pacifier or sucks their thumb? _____

What other comforting measures does your child use (blanket, toy, other)? _____

Does it have a name? _____

Social Relationships

How would you describe your child's general disposition (cheerful, moody, happy, quiet, aggressive, shy, etc.)? _____

Does your child have temper tantrums? How do you deal with them?

How do you generally discipline your child at home? _____

Does your child have any fears? What are they and how do you handle them?

How does your child relate to strangers? _____

Does your child enjoy playing with other children? Are there playmates your child will talk about (such as siblings, cousins, neighbors, etc.)?

What is your child's favorite toy? _____

What does your child like to do the most? _____

Are there family beliefs that you would like to share with us (ex. special celebrations, dietary restrictions, cultural activities or traditions)?

What else would you like us to know about you and your child to help us plan for the most comfortable entry into our program?

What goals do you have for your child? _____