

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Nickname \_\_\_\_\_

**DEVELOPMENTAL, SOCIAL AND HEALTH HISTORY**

*We want to provide your child with the best care possible. Please help us get to know your child by filling out this questionnaire. Thank you!*

**Daily Living Routines**

***Sleeping***

Please describe your child's usual bedtime routine.

Does your child sleep well? \_\_\_\_\_ About how long each night? \_\_\_\_\_

What is your child's usual bedtime? \_\_\_\_\_

Does your child nap? \_\_\_\_\_ How many times per day? \_\_\_\_\_ How long? \_\_\_\_\_

Does your child sleep with a special blanket or toy? \_\_\_\_\_

Does your child go to bed with a pacifier? \_\_\_\_\_ Bottle? \_\_\_\_\_

Does your child have sleep disturbances - nightmares, sleepwalking, waking at night or difficulty

Yes No

If Yes, please describe \_\_\_\_\_

Do you have any concerns about your child's sleep habits?

---

***Eating***

Would you say your child generally enjoys eating? \_\_\_\_\_

What are some of your child's favorite foods? \_\_\_\_\_

Is your child on any special diet? Describe below. (Please note: State law requires a special form signed by your child's health provider if your child has any diet modifications)

---

Does your child have any allergies? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are there any foods you do not want us to offer your child?

Are there any foods special to your home or culture that you would like us to offer?

What does your child use to drink? (*Please circle all that apply*)      Bottle      Tippy Cup      Regular cup

\_\_\_\_\_

If your child uses a bottle, what type of nipple? \_\_\_\_\_

How does your child eat?      Hands      \_\_\_\_\_      Spoon      \_\_\_\_\_      Fork      \_\_\_\_\_

Do you have any concerns or questions about your child's eating?  
\_\_\_\_\_

***Morning Routine***

Does your child eat breakfast before coming to day care?

Yes       No

Can your child dress him/herself?    Yes     No

Do you have a morning routine that helps your child prepare for child care?

\_\_\_\_\_

offer some useful suggestions!

***Toileting***

Does your child use diapers?	Yes	_____	No	_____
If yes, what kind?	Disposable	_____	Cloth	_____
If cloth, what type of cover?	Plastic pants	_____	Diaper wraps	_____

Is your child potty trained? \_\_\_\_\_

Does your child use a potty or the toilet? \_\_\_\_\_

Does your child use training pants? \_\_\_\_\_

How does your child let you know that it's time "to go"? \_\_\_\_\_

Families tend to use a variety of words to describe bathroom activities. What words does your child use

urine      \_\_\_\_\_      bowel movement      \_\_\_\_\_

genital area      \_\_\_\_\_

Do you have any questions or concerns about your child's toilet habits? \_\_\_\_\_

\_\_\_\_\_

not permitted to launder diapers on the premises.

***Physical Health***

**Your child's regular health care provider:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Last physical exam: \_\_\_\_\_

**Your child's dentist:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Last dental exam: \_\_\_\_\_

Would you like assistance finding a health care provider or dentist?

Yes \_\_\_\_\_ No \_\_\_\_\_

**Immunizations:** Please complete the immunization form. State law requires that all children be

Has your child had any health problems in the past? \_\_\_\_\_ If yes, please describe.  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any health problems presently? \_\_\_\_\_ If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any chronic health conditions? (For example, asthma, epilepsy, diabetes)

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please fill out the chronic health form

Does your child have any developmental delays, special needs or learning problems?

If yes, please explain. \_\_\_\_\_

(Would you be interested in meeting with the teachers and directors to help us plan to meet your child's needs?)

Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child using any medication at this time? \_\_\_\_\_ If yes, please explain.

(Please include ointments, drops, over-the-counter medications, and lotions)

\_\_\_\_\_  
\_\_\_\_\_ medications must be in their original containers with your child's name printed on the label along with the pharmacy's

Do you have any concerns about your child's health? \_\_\_\_\_ If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

Children in group care become ill with colds, viruses, etc. several times per year. At times, we are

Do you have a "back-up" plan in case your child is ever excluded from child care? Please provide

Name:

\_\_\_\_\_

Phone:

\_\_\_\_\_

Relationship

\_\_\_\_\_

**Development**

Do you have any concerns or questions about your child's hearing? \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

Do you have any concerns or questions about your child's vision? \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

What is your child's primary language? \_\_\_\_\_

What languages are spoken in your home? \_\_\_\_\_

Do you have any questions or concerns about your child's speech and language development? \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

Do you have any concerns or questions about your child's ability to move? \_\_\_\_\_

**Social and Emotional Development**

Has your child been in child care before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many different places? (Please list)

\_\_\_\_\_  
\_\_\_\_\_

How does your child respond in group situations? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child enjoy playing with others? \_\_\_\_\_

\_\_\_\_\_

Does your child enjoy playing alone? \_\_\_\_\_

\_\_\_\_\_

What kinds of activities does your child enjoy? (Games, TV, outdoor play, watching others, puzzles, blocks, books)

\_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's temperment and personality? (Examples: quiet, shy, moody, intense,

\_\_\_\_\_  
\_\_\_\_\_

What is the best way to comfort your child? \_\_\_\_\_  
\_\_\_\_\_

How do you guide/teach your child correct behavior? \_\_\_\_\_  
\_\_\_\_\_

Does your child fear certain things? (For example, loud noises, dogs, the dark, clowns)  
\_\_\_\_\_

Upsetting events, losses (such as separation, divorce, or death in the family) and change can affect  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Who lives at home with your child? \_\_\_\_\_  
\_\_\_\_\_

Do you have any questions or concerns about your child's social and emotional development or behavior?  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

What can we do to help ease your child's adjustment to child care?  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to see your child gain/learn at our child care center? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any questions about our health and safety policies, this questionnaire or anything else?  
\_\_\_\_\_  
\_\_\_\_\_