Getting to Know Your Child

Child's Name:_____________________________ Nickname: ____________________________

Child's birth date: ______________ Sex: M F Start Date:______________________

Socialization

Has your child had previous group experience? Yes___ No_____

If yes, please describe: ____

How does your child get along with other children? _______________________________

Circle the social approaches that describe your child:

Shy__ Friendly__ Cautious__ Outgoing___

How much assistance does your child need in managing routines, such as dressing, toileting and eating?

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____

If your child has any fears, please describe:

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Communication

Does your child understand directions given? Yes____ No_____

Does your child speak to adults? Yes____ No_____

Does your child use short phrases or sentences? Yes____ No____

Does your child use non-verbal gestures? Yes____ No_____
Please elaborate on any of the above as needed:____________________________________

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Is English the primary language spoken in your home? Yes____ No______

If no, what is the primary language spoken? ____

Is there a second or third language spoken in the home? Yes___ No_____

If yes, what other language/s is/are spoken? _______________________________________

Emotional Behavior

Does your child like to be held when upset? Yes____ No_____

Does your child cry easily? Yes____ No_____

Does your child have difficulty separating from parents? Yes____ No_____

What are your child's likes/dislikes:

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What behaviors do you consider most difficult to deal with?

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What type of discipline(s) do you use at home?

By Mom: ____

By Dad: ____

Sleeping Habits

What is your toddler's bedtime? (PM)_______ What time does he/she wake:________ (AM)

Does your toddler take naps regularly? Yes_____ No______ If yes, length: _______________

Is your child a light/heavy sleeper? Light______ Heavy______

Does your child use a security object to fall asleep? _______

Blanket Stuffed Animal Doll Pacifier Other ______________

Does you have any special ways of helping your infant fall asleep? Yes_____ No______

If yes, please describe:

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Eating Habits

Is your child able to use silverware? Yes_____ No_____

Does your child need a bib when eating? Yes_____ No_____

Is your child able to wash his/her hands/face? Yes____ No_______

What time does your child usually eat? (B)_____ AM (L) _____ AM / PM

Does your child have any food allergies/sensitivities? Yes_____ No_______

If yes, describe: ____

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Favorite Foods: ____

Least Favorite Foods: ____

Any additional information you would like to share regarding your child's eating habits?

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Diapering/Toilet Training

Frequency of diaper changes? __________

Does your child have any reoccurring rashes or other problems? Yes_____ No_____

If yes, please describe: ____

Words used at home for urination or bowel movements: ______________________________

When does your child use the toilet?

Doesn't_____ Urinating_______ Bowel Movements____________

If a boy, does your child sit or stand when urinating? Yes____ No_____

What routines are followed for regular toileting? ______________________________________

Does your child need to be reminded? Yes____ No_____

Does your child need help re-dressing after toileting? Yes_____ No_____

Does your child sleep with a diaper/pull-up? Yes_____ No______

If no, does your child typically stay dry during naps? Yes______ No______

What else should we know about your child? ____