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?

_____

_____

_____

_____

_____

_____

If your child has any fears, please describe:

_____

_____

_____

_____

_____

_____

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:_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

What behaviors do you consider most difficult to deal with?

_____

_____

_____

_____

_____

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:

_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

Favorite Foods:

_____

Least Favorite Foods:

_____

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

_____

_____

_____

_____

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? _____

_____

_____