Child History

ALL ABOUT ME

Child's Name: _____ DOB: _____/_____/_____ Age: _____
First Middle Last

Nickname? _____ Brothers/Sisters? (Names & Ages) _____

Pets? (Names & Species) _____

Special Interests/Hobbies/Activities at Home: _____

_____

Personality Traits: _____

Has the child attended a preschool setting previously? _____ Dates Attended: _____

Reason for Leaving: _____

Does your child play well with others? _____ Has your child had experience with the following: (✅)
( ) Grasping Writing Utensils ( ) Cutting with Scissors ( ) Stacking Blocks ( ) Puzzles ( )Finger Painting

GENERAL INFORMATION

Is your child **adopted**? ☐No ☐Yes If yes, at what age? _____

Who is filling out this form?
☐Mother
☐Father
☐Other guardian (please explain relationship to child) _____
☐Other (please explain) _____
_____

The child's parents are:
☐Single ☐Married ☐Divorced ☐Separated but not divorced
☐Widowed ☐Living together but not married ☐Unknown

Comments: _____

SLEEPING HABITS

Does your child have a regular bedtime schedule? _____ What time nightly? _____

What time does your child wake up? _____ Does your child have trouble sleeping? _____ If yes please explain: _____ Does your child nap? _____
How long are the naps? _____ Time of day? _____ til _____
Any sleeping rituals/habits needed for sleep routines? _____ If yes, please explain: _____
_____

EATING HABITS

Favorite Foods: _____

Disliked Foods: _____

Food Allergies? _____ If yes, explain: _____

Can your child drink from a cup or does he/she need a sippy cup? _____

Is your child a self-feeder or does he/she need to be hand fed? _____

Will your child be eating breakfast at home or school? _____ Any Eating Habits? _____

Comments: _____

HEALTH INFORMATION

Does your child have any known health conditions? _____ Comments: _____

Does your child regularly take medication? _____ If yes, what medication: _____

How often does your child take medication? _____

Has your child ever contracted any of the following, Measles - Mumps - Chicken Pox? _____

Is your child prone to any of the following: Upset stomach, colds, seasonal allergies, earaches, headaches, sore throats, nose bleeds, other: _____ If yes, which? _____

Does your child have vision problems? _____ Hearing difficulty: _____ Mental or Physical Disability? _____ Comments: _____

Recent Illness? _____(If yes, explain)_____

Do you have a plan in place if your child is sick and needs to be picked up from school? _____

If yes please explain: _____