DEVELOPMENTAL HEALTH HISTORY
Infant, Toddlers and Preschool

Child's Name _____ Nickname _____ Birthdate _____

PHYSICAL HEALTH

What health problems has your child had in the past? _____
_____

What health problems does your child have currently? _____
_____

Other than what you listed above –

Does your child have any allergies? Is so, to what? _____
How severe? _____

Does your child take any medicine regularly? If so, what? _____
_____

Does your child have any recurring chronic illness or health problems such as:

_____ asthma _____ cerebral palsy _____ developmental delay
_____ diabetes _____ frequent earaches _____ hemophilia
_____ seizure disorder other _____

Do you have any other concerns about your child's health? _____
_____

DEVELOPMENT (Compared to other children this age).

Does your child have any problems with speech? Please explain. _____
_____

Does your child have any problems with walking, running or moving? Please explain._____
_____

Does your child have any problems with seeing? Please explain. _____
_____

Does your child have any problems with hearing? Please explain. _____
_____

DAILY LIVING

What is your child's typical eating pattern? _____
_____

Is your child on any special diet? Please describe _____
_____

Other side

Write N/A (non-applicable) if your child is too young for the following questions to apply:

What foods does your child like? _____
Dislikes and how does he/she express it? _____

How well does your child use table utensils (cup, fork, spoon)? _____

How does your child indicate bathroom needs? _____

Special words for body parts: _____

What are your child's regular bladder and bowel patterns? Do you want us to follow a particular plan for toileting? _____
_____

For toddlers, please describe use of diapers or toileting equipment (such as potty, toilet seat, etc.) _____
_____

What are your child's regular sleeping patterns?
Awakes ate _____ Naps at _____ Goes to bed at _____

What help does your child need to get dressed? _____

SOCIAL RELATIONSHIPS/PLAY

What ages are your child's most frequent playmates? _____

Is your child friendly? _____ Aggressive? _____ Shy? _____ Withdrawn? _____

Does your child play well alone? _____

What is your child's favorite toy? _____

Does he/she have a comforting item? (such as a blanket, stuffed animal, etc) _____

Is your child frightened by (circle all that apply)Animals? Rough Children? Loud Noises? The Dark? Storms? Anything else? _____

What does your child do when he/she is stressed, angry, or frustrated? _____
_____

What is the best way to discipline your child, EXCLUDING physical punishment? _____
_____

Is there any other information that you wish to share that would assist in meeting your child's needs? _____
_____
_____
_____

Parent's Signature _____ Date _____

Teacher's Review _____ Date _____