



Developmental/ Behavior History Form

Child's Name: _____ Age: _____ DOB: _____ Sex: _____

Personal History

Birth Wt. _____ City/State of Birth _____

Name all persons living in household with child.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Name all persons helping raise this child in or out of the household.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Was this child adopted? _____ Does he/she know? _____ Age of child when adopted? _____

Emotional History

Describe your child's temperament. (shy, talkative, aggressive, etc.)

What things or events upset your child? (vacuum, thunder, sirens, animals, etc.)

How does your child act with strangers or in unfamiliar settings?

Has your child spent much time playing and socializing with other children? If so, explain. (siblings, play groups, other daycare, etc.)

Describe your child's daily routine. Begin with wake up, end with bed time and please include the time of each activity.

Health History

List all allergies, include foods, medicine, etc.

List all serious injuries and their date.

List all hospitalizations and their date.

Has your child ever had any speech/hearing/vision problems? (Describe)

How does your child act when sick? (no appetite, sleep a lot, fussy, etc.)

Does your child run a temperature easily? (100 degrees or higher) Yes or No

Has your child ever had a convulsion related to a fever? Yes or No

Is your child on medication now? (Describe) Yes or No

Diet History (circle all that apply)

What does your child eat?

Table food milk/formula baby food baby cereal juice

What does your child use to eat/drink?

Cup bottle cup w/lid spoon fork fingers

What type of milk/formula does your child drink?

Breast milk whole milk 2% 1% skim formula (_____ brand)

Describe any food your child may be allergic to and describe reaction.

Does your child have problems with

Spitting up? Constipation? Loose stools? Diaper rash? Gas pains? Sensitive skin?

If taking a bottle, what kind is used and how often do you burp the child?

How does teething affect your child?

What meals does your child eat?

Breakfast lunch dinner/supper am snack pm snack bed time snack

What kind of eater is your child?

Eats everything on plate eats half of food served eats a few bites

If your child is on a special diet, state reason and explain diet in detail.

Bowel/Bladder History

At what age was bowel control achieved? _____ Bladder control? _____

How many BM's per day does your child have? _____

What word does your child use for BM? _____ Urine? _____

Sleep History

Child's bedtime is _____ child wakes at _____

Naps are from _____ to _____ (list both am and pm naps if applicable)

My child hasn't napped since age _____

Items my child sleeps with _____

Mood when waking up is _____

How is your child put to sleep? Be specific (needs to be rocked, patted, needs music, needs blanket, sleeps on tummy, etc.)

Describe child's sleep pattern. (heavy, light, restless, etc.)

Miscellaneous

What discipline techniques work for you child?

Tell us anything about your child that will help us better care for him/her.

Are there any key words or phrases that your child uses to describe specific needs? Explain
