

# ABOUT YOUR CHILD

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Mother's Occupation \_\_\_\_\_

Siblings' Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Birth: Normal \_\_\_\_\_ Premature \_\_\_\_\_ Overdue \_\_\_\_\_ Caesarean \_\_\_\_\_

Complications \_\_\_\_\_ Birth Weight \_\_\_\_\_

Serious illness or hospitalization during the past 12 months? \_\_\_\_\_ Describe \_\_\_\_\_

Is child currently taking any long term medication? \_\_\_\_\_ Describe \_\_\_\_\_

Does your child have allergies? \_\_\_\_\_ Describe \_\_\_\_\_

Previous School Experience \_\_\_\_\_

What extracurricular activities does your child participate in? \_\_\_\_\_

## EATING HABITS

How many meals each day does your family eat together? \_\_\_\_\_

How would you describe your child's appetite? \_\_\_\_\_

What is your child's best meal? Breakfast? \_\_\_\_\_ Lunch? \_\_\_\_\_

Dinner? \_\_\_\_\_ Snacks? \_\_\_\_\_

Favorite Foods? \_\_\_\_\_

## BEDTIME HABITS

Awakens? \_\_\_\_\_ Naps? \_\_\_\_\_ Goes to bed? \_\_\_\_\_

Does your child sleep through the night? \_\_\_\_\_

Does he/she sleep alone? \_\_\_\_\_ in own bed? \_\_\_\_\_ in own room? \_\_\_\_\_

## PARENTING

What method of correction is most effective with your child? \_\_\_\_\_

How do you see yourself in the parenting role? \_\_\_\_\_

How do you see your spouse in the parenting role? \_\_\_\_\_

EVERY CHILD IS UNIQUE

What are your child's strengths? \_\_\_\_\_

\_\_\_\_\_

With what do you feel your child needs the most help? (e.g. social skills, fine motor, gross motor, speech and language, readiness skills) \_\_\_\_\_

\_\_\_\_\_

What are your child's favorite things? \_\_\_\_\_

\_\_\_\_\_

What are your child's least favorite things? \_\_\_\_\_

\_\_\_\_\_

What is the MOST wonderful thing about your child? \_\_\_\_\_

\_\_\_\_\_

Comments: