INFANT/TODDLER DEVELOPMENT HISTORY

Child's Name: _____
Birth Date: _____
Today's Date: _____

HEALTH

1. Does your child seem well most of the time? ____Yes ___No
2. Is your child taking any medications now? (including aspirin, laxatives, vitamins, etc.?) ____No ___Yes/List:_____
3. In a year, has your child had as many as three ear infections? ____Yes ____No
4. Are you concerned about your child's hearing? ____Yes ____No
5. In a year, does your child usually have more than three colds or sore throat infections with a fever? ____Yes ____No
6. Are you concerned about your child's eyes or vision? ____Yes ____No
7. Has your child been seen by a medical specialist? ____Yes ____No
8. What arrangements have you made should your child become ill at the Center? _____
9. Does your child have any handicaps? ____Yes ____No
10. Has your child been hospitalized? ____Yes ____No
    If yes, please describe: _____
11. Other illnesses or disease? _____
12. Has your child had any serious accidents or poisonings? ____Yes ____No
13. Does your child chew any unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, hair…? ____Yes ____No
14. Has your child had any of the following? Please Check: ____Premature Birth, ____Birth Injury or Defect, ____Convulsions or Seizures, ____Allergies (Eczema, hives, drug, food tolerance, hay fever, wheezing, asthma, insect stings). Please describe: _____

DEVELOPMENTAL HISTORY

How do you comfort your child? _____
What are your child's favorite toys? _____
What are your child's favorite activities? _____
What language is spoken at home? _____

SLEEPING

Do you have any special ways of helping your child get to sleep?_____
_____

-OVER-

What is your child's present sleeping schedule?

Night Time: From _____ To_____
a.m. Nap: From _____ To_____
p.m. Nap: From _____ To_____

Does your child need a blanket? ____Yes ____No
Does your child need a sleeping toy? ____Yes ____No

FEEDING

What is your child's present eating schedule? (Specify Amount)

	Time	Juices	Food	Formula/Milk
Breakfast				
Lunch				
Dinner				
Snack				

Has your child had any feeding problems? ____Yes ____No
If yes, describe (include allergies or food particularly disliked) _____
_____

TOILETING

How frequently does your child have a B.M.? _____
Appearance of B.M. _____
Is your child toilet trained? _____
What word does your child use for urination? _____
What word does your child use for bowel movement? _____
Does your child use a potty chair? _____
Does your child have frequent diaper rash? ____Yes ____No
How is it treated? _____
Can your child easily manage the types of clothing he/she wears? ____Yes ____No

COMMUNICATION HABITS

How does your child communicate needs or wants to people? _____
_____
What kinds of things could we do to better communicate to your child? _____
_____