6 Weeks – 36 Months Developmental History

To be completed by parent(s) and/or guardians

Child's Full Name: ______________________________ What names do you call your child: ______________________

Child's Birth Date: _____ /_____ /_____ Gender:__________ Today's date: _____ /_____ /_____

A. About Your Family

1. Mother's name: ________________________________ Occupation: ____________________________
2. Father's name: ________________________________ Occupation: ____________________________
3. Marital status of parents: _________________________ Are both parents living at home? Yes No
4. Custody/Living arrangements: ____
5. Has there been a change in the family recently that may affect your child? Ex: death, divorce or illness. Yes No
   If yes, please explain: ____
6. Did your child attend another child care? Yes No If yes, in home: ______ Center______

B. About Your Child

1. How does your child communicate their wants and needs? ____
2. How do you comfort your child? ____
3. What is your child's favorite toys and activities? ____
4. What language(s) is spoken in your home? ____
5. Do you have behavior problems with your child? Yes No
   If yes, describe: ____
6. How do you handle/prevent them? ____
7. How does your child react to babysitters, new people, and new situations? _________________________
   ____
8. Are you aware of any fears or anxieties your child has? Yes No
   If yes, describe: ____

C. Sleeping

1. Do you have any specific ways of helping your child go to sleep?_______________________________________
   ____
2. What is your child's current sleep schedule?
   AM naptime: ______ to ______
   PM naptime: ______ to ______
   Bedtime: ______ to ______
3. Does your child use a special toy at naptime? Yes No
4. Does your child use a blanket at naptime? Yes No
5. Does your child use a NUK at naptime? Yes No

D. Feeding

1. What is your child's present eating plan?
   Breakfast: ____
   Lunch: ____
   Snack: ____
2. Does your child have any food allergies? Yes No
   If yes, what? ____
3. Is your child on a special diet? Yes No
   If yes, what? ____
4. Does your child have any feeding problems? Yes No
   If yes, what? ____
5. Formula: ________ Breast Milk: ________ Have solids been introduced? Yes No
6. Favorite Foods: ____
7. Disliked Foods: ____

E. Toileting

1. How frequently does your child have a bowel movement? ______________________________
   Is there a problem with: Diarrhea or Constipation (circle)
2. Does your child frequently have a diaper rash? Yes No
   How is it treated? ____
3. Is your child toilet trained? Yes No
4. What word does your child use for urination? _____________________________________
5. What word does your child use for bowel movement? _________________________________
6. Does he/she use a potty chair, special seat or regular seat? If yes, circle Yes No
7. Can he/she easily manage the types of clothing worn? Yes No
8. If toilet trained, does your child frequently have accidents? Yes No N/A

F. Developmental History

1. Age your child began: Sitting: ______ Crawling: ______ Walking: ______ Talking: ______
2. Does child: Pull self-up: ______ Crawl: ______ Walk with support: ______ Without support: ______