EPISCOPAL HOMES

INFANT/TODDLER/TWOS DEVELOPMENTAL HISTORY

Child's Name: _____ Date of Birth: _____/_____/_____

DEVELOPMENTAL HISTORY
Age child began sitting: _____ crawling _____ walking _____ talking _____

Does child: · pull up · crawl · walk with support

Times child is fussy: _____

How do you handle these fussy times? _____

How does your child communicate his/her needs? _____
_____
_____

FAMILY INFORMATION

With whom does child reside? _____

Who else lives in the home (siblings, extended family, pets)? _____
_____

What does child call family members?_____

Language spoken at home: _____

Are books read in languages other than English? _____

Are there words in your home language that we should know?_____
_____

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: _____
_____
_____

HEALTH/ DEVELOPMENT
Serious illnesses or hospitalizations (describe)?_____
_____
_____

Special physical conditions, disabilities, or allergies (describe)?_____
_____
_____

Is your child presently or ever been diagnosed with a special need?_____

If so, is he/she receiving any special services?_____

Regular medications? _____

EATING HABITS

Special characteristics or difficulties? _____

Special diet: _____ Formula: _____ Breast Milk: _____

Any food allergies? _____

Have solid foods been introduced? · yes · no If yes, please identify: _____

_____

Favorite foods: _____ Foods refused: _____

Child eats: · on lap · in high chair · other

Child eats with: · spoon · fork · hands · other

TOILETING/DIAPERING HABITS

Is there frequent diaper rash? · yes · no

Do you use: · oil · powder · lotion · other

Does child wear: · disposable diapers · cloth diapers

Are bowel movements: · regular how often: _____

Is there a problem with: · diarrhea · constipation

Is your child toilet trained: · yes · no If yes, when did you begin? _____

· urination · bowels or · both

What is used at home: · potty-chair · special seat · regular seat

Word used for urination: _____ bowel movement: _____

Does your child have accidents? · yes · no If yes, how often/when?_____

_____

SLEEPING HABITS

Does child sleep in: · crib · bed · with parents

Does child sleep on: · back · side · stomach

Times child take naps? Times: a.m. _____/_____ p.m_____/_____

What does child take to bed? _____ mood on awakening_____

What time does child go to bed at night: _____awake in morning: _____
Are there any sleep/wake time rituals? If so, please describe._____
_____
_____

SOCIAL RELATIONSHIPS
Has child had any experience playing with children? If so, please describe._____
_____
_____
_____

Is child: · friendly · aggressive · shy · withdrawn
Reaction to strangers? _____
_____

Have you had any previous child care experience? · yes · no If yes, did it meet your needs and expectations? Explain:_____
_____
_____

Prefers to play: · alone · in small groups

Favorite toys and activities?_____
_____

Is child frightened by: · animals · rough children · loud noises · dark · other
Explain: _____

How do you comfort your child?_____
_____
_____

How does your child prefer to be held? _____
_____

What is your style of disciplining? _____
_____
_____

DAILY SCHEDULE
Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

MORNING AFTERNOON
_____
_____

_____

PARENTING PHILOSOPHY

Do you have ideas about parenting that would help us to better care for your child as an individual? _____

What do you, as a family, hope to get out of this child care experience?_____

_____ _____

(Parent/Guardian's Signature) (Date)