earlyconnections℠
LEARNING CENTERS

DEVELOPMENTAL HISTORY

ALL INFORMATION IS CONFIDENTIAL - FOR STAFF USE ONLY

Today's Date _____

Child's Name _____
First Middle Last

Date of Birth _____ Child is: Biological ☐ Adopted ☐ Foster ☐ Guardian ☐

How do you prefer to be contacted for a non-emergency (phone, e-mail, note, etc.)?

I. Family/Home Information

There is no one more important to children than the people in their family. Knowing more about the special people in your child's life and what is important at home will help us be more responsive to your child.

Members of Household	Relationship to Child	Age	Does child have a special name for this person?
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

If either of the parents does not live with the child, please describe the child's relationship with that parent, such as how often the child sees that parent, if at all; other members of this parent's household; child's experience transitioning from one household to another, etc.

Are there other significant people in your child's life that you would like us to be aware of? If so, please describe their relationship to your child and what your child calls them.

Is English the primary language spoken in the home? Yes / No

What other languages are spoken in your home?

II. Child/Family History

Has your child had a previous preschool or childcare experience? Yes / No

Does your child have a current IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? Yes / No
If yes, from where? _____

Does your child currently attend a preschool or childcare? Yes / No
If yes, which one? _____

What major changes have occurred in your family or child's life over the last year? _____

_____

Has your family ever experienced a suicide within the immediate family? Yes / No

Has your family experience family violence within your child's lifetime? Yes / No

Has your child ever experienced a traumatic event? Yes / No If yes, please explain: _____

_____

Does anyone in your family have a history of alcoholism? Yes / No If yes, who? _____

Does anyone in the household have a history of drug addiction? Yes / No If yes, who? _____

Does anyone in the household have a history of mental illness? Yes / No
If yes, please explain type and who:_____

Does anyone I the family have a learning disability? Yes / No
If yes, please explain type and who: _____

If you have more than one child in the household, do you feel your children are overly violent with each other? Yes / No

Is your child overly defiant or does he/she display aggressive behavior s that concern you? Yes / No
If yes, please answer the next series of questions:
Does your child cause harm to other children or animals? Yes / No
Does your child ever cause harm to him/herself when behavior is out of control? Yes / No
Has your child ever been asked to leave a child care setting due to unresolved behavioral issues? Yes / No
Do you feel that your child is depressed, fearful, sad or overly worried? Yes / No?

Please check those that describe your child:

☐ Affectionate and loving	☐ Dislikes changes in routine	☐ Has staring spells
☐ Avoids attention	☐ Doesn't pay attention	☐ Has temper tantrums
☐ Bangs head repeatedly	☐ Falls a lot	☐ Holds breath
☐ Bites Nails	☐ Clumsy	☐ Has a sense of humor
☐ Impulsive	☐ Creative	☐ Has fears
☐ Prefers to be alone	☐ Curious	☐ Has sleep problems
☐ Shows dare-devil behavior	☐ Shy or timid	☐ Stubborn
☐ Well-coordinated		☐ Other

III. Napping Information (Infants, Toddler and Preschool children only)

Does your child sleep with a comfort item (special blanket, stuffed animal, pacifier)?

Yes ☐ No ☐ If yes, what? _____

How does your child usually fall asleep at naptime? (Quiet music, back rubbed, etc.)

IV. Nutrition Information

What is a regular mealtime like in your home? (Any rituals or traditions associated with the meal? Who eats together? Where?)

Are there foods eaten in your home that are part of your cultural heritage?

Yes ☐ No ☐ If yes, what? _____

Are there any foods your child cannot eat because of religious or cultural traditions?

Yes ☐ No ☐ If yes, what? _____

V. Health Information

Please describe how you know when your child needs to use the toilet. What words does your child say to ask to use the toilet?

Has your child had (or have) any of the following? (Please check all that apply)

☐ Allergies (food, medication, etc.)
☐ Asthma
☐ Anemia
☐ Autism
☐ Behavioral Disorders
☐ Bone/Orthopedic Problems
☐ Frequent Ear Infections/Tubes
☐ Dental Problems
☐ Developmental Disabilities
☐ Diabetes
☐ Down's Syndrome
☐ Feeding/Eating Problems
☐ Traumatic Brain Injury
☐ Cerebral Palsy
☐ Speech Problems
☐ Heart Problem/Condition
☐ Learning Disabilities
☐ Seizures
☐ Sickle Cell Anemia
☐ Fetal Alcohol Syndrome
☐ Difficulty at birth
☐ Other

Please explain any medical history items checked.

Does your child wear glasses? ☐ Yes ☐ No