

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 in 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 behaviors 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies (food, medication, etc.) | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Heart Problem/Condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Feeding/Eating Problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Behavioral Disorders | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Fetal Alcohol Syndrome |
| <input type="checkbox"/> Bone/Orthopedic Problems | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mongolian Blue Spots |
| <input type="checkbox"/> Current Medications | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Frequent Ear Infections/Tubes | | |
| <input type="checkbox"/> Dental Problems | | |

Please explain any medical history items checked.

Does your child wear glasses? Yes No