Riviera
Preschool Childrens Center

Child's Personal History

Family and Social History

Name of Child:_____ Date of Birth:_____

Mother or Guardian:_____

Father or Guardian:_____

Siblings of Child:

Name:_____ Date of Birth:_____ Grade in School:_____

Name:_____ Date of Birth:_____ Grade in School:_____

Name:_____ Date of Birth:_____ Grade in School:_____

Has child had group play experience?_____ If so, where?_____

Does child have neighborhood playmates?_____ If so, specify:_____

Developmental History of Child

Age at which child: crept on hands and knees _____

sat alone _____

walked alone _____

named simple objects _____

began toilet training _____

Word child uses for: urination_____ bowel movements_____

Usual time for B.M. _____

Does child dress self?_____ Undress self?_____

Is child right or left handed?_____

What time does child usually eat breakfast?_____ lunch?_____ dinner?_____

Is the family vegetarian?_____ Please list any other dietary restrictions:_____

_____

What time does child usually go to bed at night?_____ Awaken?_____

Does your child usually sleep well?_____

What are your child's favorite indoor play activities?_____

outdoor activities?_____

Does your child play with water?_____ Go barefoot?_____

Does your child have any special fears that you are aware of?_____

Does your child have any speech problems?_____

Does your child have any other problems we should be aware of?_____

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What method of behavior control is used in your home? _____

_____

What is your child's usual reaction? _____

_____

How would you describe your child's personality? _____

_____

Health History of Child

What past illnesses has your child had? At what age?

chicken pox_____ scarlet fever_____ diabetes_____

mumps_____ measles_____ hepatitis_____

tonsillitis_____ other_____

Does your child have frequent colds? _____ If yes, explain:_____

ear aches? _____ stomach aches? _____

Does your child vomit easily? _____Does your child run high fevers easily? _____

Has your child had any serious accidents? _____If yes, explain:_____

Does your child have allergic reactions? _____If so, how does it usually manifest itself?

asthma_____ hay fever_____ hives_____ other_____

What causes your child's allergic reactions?_____

Has your child ever been to a dentist? _____ If so, at what age? _____

Has your child had his/her vision tested?_____ hearing tested? _____

Does your child wear corrective shoes? _____

Please use the remaining space below to give a statement of your evaluation of your child's overall health. Be sure to include anything not previously listed above.

_____

_____

_____

_____

_____

_____

_____