

Class: \_\_\_\_\_

**Developmental History**

Date: \_\_\_\_\_

*Kids in Discovery Preschool is dedicated to providing your child with a happy, secure environment. By sharing your child's developmental history with us, we can better serve his/her needs.*

CHILD'S NAME: \_\_\_\_\_ Birth date: \_\_\_\_\_

1. Others in household: List names & ages of all siblings (at home and not at home), stepchildren, and adults in your household: \_\_\_\_\_  
\_\_\_\_\_
2. Has your child had experiences playing with other children?  Yes  No  
Neighborhood friends: \_\_\_\_\_ Daycare: \_\_\_\_\_
3. How do you feel your child relates to other children? \_\_\_\_\_  
\_\_\_\_\_
4. Would you describe your child as friendly, aggressive or shy? \_\_\_\_\_  
\_\_\_\_\_
5. Does your child enjoy playing alone?  Yes  No \_\_\_\_\_
6. Does your child speak any language other than English?  Yes  No  
List which language (s) \_\_\_\_\_
7. Does your child know any other children who attend KIDS? \_\_\_\_\_  
\_\_\_\_\_
8. What upsets your child? \_\_\_\_\_
9. Have there been any changes in your family structure which may have affected your child (i.e. birth, death, adoptions, divorce, separation) \_\_\_\_\_
10. How does your child react in stressful situations? \_\_\_\_\_  
\_\_\_\_\_
11. How do you discipline your child? \_\_\_\_\_
12. Please list any pets your child has: \_\_\_\_\_
13. Does your child enjoy:  Stories  Music  Outside play? \_\_\_\_\_
14. Has your child had experience with:  Scissors  Blocks  Easel paint  
 Markers  Finger paint  Play dough
15. At what age was your child toilet trained? \_\_\_\_\_ Urine? \_\_\_\_\_ Bowels? \_\_\_\_\_  
Can your child take care of his/her toilet needs?  Yes  No
16. Is your child a  good  average or  poor eater? Does s/he eat a good breakfast?  Yes  No  
Does your child have any dietary restrictions?  Yes  No  
If so, please indicate restriction: \_\_\_\_\_
17. Has your child had a serious illness, surgery or hospital stays? \_\_\_\_\_  
\_\_\_\_\_

18. Does your child sleep well? Yes No What is your child's bedtime? \_\_\_\_\_
19. Does your child have allergies? Yes No If so, please indicate: \_\_\_\_\_
20. Is your child taking regular medication? Yes No If yes, please indicate: \_\_\_\_\_  
\_\_\_\_\_
21. Has your child attended Sunday School? \_\_\_\_\_
22. Has your child received any:  Speech Therapy  Occupational Therapy  Other Services  
Please detail: \_\_\_\_\_
23. Are there any special celebrations or cultural traditions of which we should be aware?  
\_\_\_\_\_
24. Is there any other information that we need to know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_  
Please print name

Relationship to child: \_\_\_\_\_

Date: \_\_\_\_\_