

SOCIAL HISTORY/HEALTH FORM



Child's Name: _____

SOCIAL RELATIONSHIPS: Is Your Child: Friendly Shy Aggressive

Describe Personality/Temperament: _____

Reaction to Strangers: _____

Child's Fears: _____

Favorite Toy, Object, or Action That Helps Calm Child When Upset: _____

If Not in Diapers, What Does Your Child Say When He/She Has to Use the Bathroom? _____

FAMILY COMPOSITION:

Siblings: _____ Nickname: _____ Age: _____ Siblings: _____ Nickname: _____ Age: _____

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Other (Grandparents, etc.): _____ Pets: _____

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SOCIAL HISTORY:

Were There Any Unusual Circumstances During the Child's Birth? _____

Was the Child Born Prematurely? (If So, How Early?): _____

Were There Any Complications After the Child's Birth? _____

If Applicable, What Age Did The Child First: Crawl: _____ Talk: _____ Walk: _____

DAILY SCHEDULE:

Does Child Sleep In: Bed Crib Other _____

What Time Does Your Child Usually Awaken in the Morning? _____

Morning Nap? From _____ to _____ Afternoon Nap? From _____ to _____

What Time Does Your Child go to Sleep at Night? _____

What Does Your Child Take to Bed (Sleep Toy, Blanket, etc.)? _____

Special Bedtime Activity (Story, Song, etc.)? _____

Are There Any Special Needs or Information the Child's Teacher Needs to Know to Assist in the Care of your Child?

MEDICAL INFORMATION:

List Any Allergies or Sensitivities: _____

Is the Child on Any Regular Medication? Yes No

If so, List: Medication -

Reason -

Time Administered -

Indicate Child's: Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

PHYSICIAN INFORMATION:

Child's Regular Physician: _____ Ph: (_____) _____

Address: _____ City: _____ State/Zip: _____