



Child's Name _____ Today's Date _____

Please describe any habits (thumb sucking, nail biting, etc.):

Please give an evaluation of your child's present physical health:

Emotional health:

Does the child have any special problems or fears?

Please give a description of your child and her/his interests and strengths and weaknesses. (Please use back of paper to respond.)

What are your concerns and expectations for your child's experience here? (Please use back of paper to respond.)

RECORD OF ILLNESS

Please check the illness your child may have had, and indicate the dates of those illnesses:

- | | |
|--|--|
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Poliomyelitis _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Other _____ |

Does your child have frequent colds?

Does your child get fast and high fevers?

What is the general nature of your child's illnesses, and what is your preference for treatment?

What is your evaluation of your child's general health?



Child's Name _____ Today's Date _____

Please describe any habits (thumb sucking, nail biting, etc.):

Please give an evaluation of your child's present physical health:

Emotional health:

Does the child have any special problems or fears?

Please give a description of your child and her/his interests and strengths and weaknesses. (Please use back of paper to respond.)

What are your concerns and expectations for your child's experience here? (Please use back of paper to respond.)

RECORD OF ILLNESS

Please check the illness your child may have had, and indicate the dates of those illnesses:

- | | |
|--|--|
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Poliomyelitis _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Other _____ |

Does your child have frequent colds?

Does your child get fast and high fevers?

What is the general nature of your child's illnesses, and what is your preference for treatment?

What is your evaluation of your child's general health?

Is there much reading in your household?

By whom?

Does your child like alone or quiet time?
time?

How does your child spend this

What regular activities do you engage in that your child watches?

Does your child have a difficult time with transitions?
Please describe:

Does your child sleep soundly through the night? or

Does your child have nightmares or unexplainable anxiety?

Does your child share fears or concerns?

SOCIAL INTERACTION

Has your child been cared for by persons other than parents?
If so, by whom?

Past peer group experience?

Who disciplines your child at home?

What forms of disciplines are used?

BIRTH/INFANCY

Briefly describe the pregnancy?

Were there any complications at birth?

Was child breastfed? How long?

At what age did child crawl? Walk? Speak?

When was child toilet trained?

Did your child have any chronic or serious illness during infancy?

Child's Name _____

Please give us an outline of your child's normal day:

