

Home Environment and Social Development

Child's Name: _____

List brothers and sisters:

Name	Sex	Date of Birth

Who lives in the home with your child?

Name	Relationship

What is the primary language spoken in your home?

How does your family define your family culture, race, religion?

What special family traditions, values or beliefs do you practice in your home?

How often does your child play with friends? (daycare, Sunday school, athletics, dance, etc.):

Describe your child's experience with other children:

Medical history

Allergies:

Food	Medicinal

Is your child on any regular medications (please circle): YES or NO

If yes, how does it alter your child's behavior?

Has child had any surgery or bone fractures?

Has physician ever been consulted with regard to speech, hearing or vision problems?

Are there any health problems in the family? Please describe how it may affect your child:

Has your child had any contagious diseases? If yes, please list:

Tell us a little about your child.

Sleep Routine

Length of time _____
(hours and minutes)

My child no longer takes naps _____ (please initial)

Night time Routine: In bed at: _____ p.m.

Asleep at: _____ p.m.

Up around: _____ a.m.

Toilet Training

Is your child potty trained? (Please circle): YES OR NO

What does child say for urination?

Bowel movement?

Behavioral Tendencies

What redirection practices are used in the home?

In what particular ways can we help your child this year?

Anything else you think would be helpful in caring for your child?