2B

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

(*To be completed by parent or guardian*)

Date______________________________

Child's Full Name ____

Date of Birth ______________________________ Race ____________ Sex ____________

Name of Parent or Guardian completing form ____

Please answer the questions on this form. We feel this information will help us be more effective in working with your child.

Childhood Disease Child has had		Date
Chicken Pox		____________
Measles	3 Day (Rubella)	____________
	10 Day (Rubella)	____________
Scarlet Fever		____________
Rheumatic Fever		____________
Mumps		____________
Strep Throat		____________

Is your child taking over-the-counter or prescribed medication regularly at home? ☐ Yes ☐ No

If yes, what?____

Is your child taking vitamins regularly at home? Yes ☐ No ☐

If yes, what?____

List any known allergies to food or environment____

Describe the allergic reaction____

Does your child complain of feeling ill often? ☐ Yes ☐ No

Have you ever suspected your child of having seizures? ☐ Yes ☐ No

Describe your child's appetite ____________________

Does your child dislike any foods? ☐ Yes ☐ No If so, what? ____________________

What does your child usually eat for breakfast before arriving at the center? ____________________

____

How easily does your child fall asleep? ____________________

What is the usual bedtime? ____________________ Wake up time? ____________________

What is the usual naptime? ____________________ Wake up time? ____________________

Is the child completely toilet trained? ☐ Yes ☐ No

Does the child remain dry all night? ☐ Yes ☐ No

When did the child begin to walk alone? ____________________

Are other adults (not family) able to understand the child's speech? ____________________

Does your child have a regular playmate? ☐ Yes ☐ No Same Age ☐ Yes ☐ No
Older ☐ Yes ☐ No Younger ☐ Yes ☐ No

What is your child's favorite toy or activity at home? ____________________

Does your child have temper tantrums? ☐ Yes ☐ No

Does your child bite his nails? ☐ Yes ☐ No Twist his hair? ☐ Yes ☐ No

If you could describe your child in one word, what would it be? ____________________

Please list your child's strong points, such as happy, curious, loving, etc. ____________________

____

Is there anything else, medical or otherwise, that we need to know about your child? ____________________

____