Toddler Developmental History

Child's Name----_____
Birthdate_____
Today's Date:_____

Health

Does your child seem well most of the time? Yes No
Is your child taking any medication? Yes No
In a year, has your child had as many as 3 ear infections? Yes No
Are you concerned about your child's hearing? Yes No
In a year, does your child usually have more than 3 colds or sore throat infections with a fever? Yes No
Are you concerned about your child's vision? Yes No
Has your child been seen by a medical specialist? Yes No
If yes, why?
Has your child had any of the following? Please circle and describe

Premature birth **Trouble breathing at birth**
Birth injury or defect **Head injury**
Convulsions, seizures **Allergies (eczemz,hives, food allergies, food tolerance, hay fever, bee stings, wheezing, asthma, insect stings)**

Developmental History

How do you comfort your child?
When they are angry?
When they are sad?
What are your child's favorite toys?
What are your child's favorite activities?
What language is spoken in your home?

Sleeping

Do you have any special ways of helping your child go to sleep?
Sleeping Schedule?

Feeding

What does your child like to eat?
Anything your child does not like to eat?

Toileting

Is your child using a toilet or potty chair?
Frequently have a diaper rash? How is it treated?

Socialization

When my child plays with other children, I notice_____

I see my child's strengths as_____
I feel that my child needs to develop skills in_____
Family traditions_____
My child lives with_____
Pets
You email address _____
Do you have any special skills or talents you would like to share with us in the classroom?