

## Background Information

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Was your child born prematurely? Yes No If yes, how premature? \_\_\_\_\_

Does your child have a nickname? \_\_\_\_\_

What name would you like your child to be called? \_\_\_\_\_

What name would you like your child to learn to write (i.e. Jennifer, Jenny or Jen)? \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Custody – Visiting Arrangements: \_\_\_\_\_

If child is adopted, list age at adoption: \_\_\_\_\_

Is child aware of adoption? \_\_\_\_\_

List siblings & ages: \_\_\_\_\_

Is your child toilet trained? Yes No Does your child nap? Yes No

What time does your child go to bed at night? \_\_\_\_\_ Wake up? \_\_\_\_\_

Do you attend First Presbyterian Church? Yes no

If no, the name of your home church \_\_\_\_\_

Does your child have any special fears? \_\_\_\_\_

Does your child have any problems with vision or hearing? Yes No

If so, please explain \_\_\_\_\_

Does your child have any health problems that we should be aware of?

If so, please explain \_\_\_\_\_

Are there any foods or drinks that your child should not have? Yes No

If so, please explain \_\_\_\_\_

Does your child have any allergies? Yes No

If so, please explain \_\_\_\_\_

Does your child take any regular medication? \_\_\_\_\_

Do you have any concerns about any aspect of your child's development?

If so, please explain \_\_\_\_\_

Age at which your child...  
 Crawled on hands and knees \_\_\_\_\_ Sat alone \_\_\_\_\_  
 Named simple objects \_\_\_\_\_ Walked \_\_\_\_\_  
 Spoke in complete sentences \_\_\_\_\_ Slept through the night \_\_\_\_\_  
 Toilet trained \_\_\_\_\_  
 Do you feel your child's speech is clear? Yes No  
 Which hand does your child use to write? Left Right  
 Which hand does your child use to eat? Left Right

What are your child's favorite activities? \_\_\_\_\_  
 Does your child play well alone? Yes No In groups? Yes No  
 Does your child accept correction easily? Yes No

Circle items below that describe your child...  
 Happy Aggressive Friendly Moody  
 Dependent Stubborn Impulsive Fearful  
 Good-natured Shy Even-tempered Sympathetic  
 Quiet Attentive Clumsy

Has your child learned to...  
 \_\_\_\_\_ Say Nursery Rhymes \_\_\_\_\_ Sing songs  
 \_\_\_\_\_ Listen to stories \_\_\_\_\_ Dress independently  
 \_\_\_\_\_ Count \_\_\_\_\_ Hop on one foot  
 \_\_\_\_\_ Write name \_\_\_\_\_ Follow simple directions  
 \_\_\_\_\_ Throw a ball \_\_\_\_\_ Name basic colors  
 \_\_\_\_\_ Balance on one foot \_\_\_\_\_ Draw a person

Has your child had group play experience? Yes No  
 Has your child attended preschool before? Yes No

What do you hope will be included in your child's preschool program?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_