PRESCHOOL INTAKE

Identification Information
Child's Name _____________________________ BirthDate ________Sex____

   If the child does not use his/her legal first name, please list the name he/she/ will be using_______________________.

Family History
   Marital Status of Parents (Voluntary Information) __________

Other Children in the Home (Name and Birth Date)
   1._________________________ 2.__________________________
   3._________________________ 4.__________________________

Physical Regime
   Does your child have any unusual eating problems, food dislikes, or allergies?
    ___________________________________________________________

   What is your child's usual bed time?_______________________

   What is your child's usual waking time?____________________

   What is your child's attitude toward going to bed and taking a nap?
    ______________________________________________________________

   How does he/she state need? Urination Bowel Movement
   How dependable is he/she? _________  _________

Please indicate any other specific needs or concerns you would like us to be aware of concerning your child.

   ___________________________________________________________
   ___________________________________________________________

Developmental History
   Please give a brief birth history of your child pertaining to length of term, any complications during pregnancy or labor and delivery, and any other pertinent information which will help us to understand your child's needs.

   ___________________________________________________________
   ___________________________________________________________

List the ages as close as you can remember when your child:

   Sat alone _______________      Said first word ____________
   Walked alone ____________   Said first sentence _________
Is your child's speech understandable to others? ______

**Medical History**

- Child has had:
  - Hospitalizations? Age and reason___________________
  - Problems in muscle or bone development?_________________
  - Serious accidents/injuries? Age and treatment____
  - Childhood Diseases?______________________________
  - Ear Infections? Treatment___________________________
  - Eye Condition? Treatment____________________________
  - Convulsions? Type and Medication____________________
  - Allergies _________________________________________
  - Has your child been treated for problems of the muscle or bone development?_______________________________

**Play and Social Development**

- How does he/she get along with children? ____________
- Has he/she had previous group experience? (play group, preschool, day care, Sunday school) _________________

**Personality and Emotional Development**

- Do you regard your child as affectionate? ____________
- To whom? _________________________________________
- Does he/she accept new people easily? ______________
- What are your child's fears? ________________________
- Is he/she usually happy? __________________________
- What nervous habits does he/she have? ______________
- When does he/she show them? _______________________
- When you find it necessary to discipline your child, which parent usually does this and how? ______________

Please give any other information which you believe will be helpful to us in understanding your child.