



TODDLER INTAKE

Identification Information

Child's Name _____ Birth Date _____ 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) _____

Other Children in the Home (Name and Birth Date)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Physical Regime

Does your child have any unusual eating problems, food allergies, specific dietary needs, or any feeding problems of which we should be aware?

What is your child's usual bedtime? _____

Usual waking time? _____

How long does your child nap? _____

Is your child potty trained? _____ Is your child working on being potty trained? _____

If yes, how does he/she state the need?	Urination	B.M.
How dependable is he/she?	_____	_____
	_____	_____

Play and Sociality

How well does he/she get along with children? _____

Has he/she had previous group experiences (play group, Sunday School, day care)?

Personality and Emotional Development

Do you regard your child as affectionate? _____ To whom? _____

Does your child accept new people easily? _____

What are your child's fears? _____

What is your child's general daily mood? _____

What nervous habits does he/she have? _____

When does he/she show them? _____

Discipline Techniques

When you find it necessary to discipline your child, which parent usually does this and how?

Developmental History

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

Sat alone _____ Said first word _____ Walked alone _____

Is your child's speech understandable to others? _____

Please give a brief birth history of your child pertaining to length of term. Were there any complications during pregnancy/labor/delivery, and any other pertinent information that will help us to understand your child's needs?

Please give any further information that you believe will be helpful to us in understanding your child (specific needs or concerns, medication your child is taking, etc.)

Medical/Surgical History

Child has had:

Hospitalizations? _____ Age and Reasons _____

Serious Accident/Injuries? _____ Age and Treatment _____

Childhood Diseases (approximate date):

Chicken Pox _____

Mumps _____

Scarlet Fever _____

Other _____

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Frequent Ear Infections ? _____ Treatment _____

Tubes/Surgery? _____ Date _____

Eye Condition? _____ Treatment _____

Glasses? _____ Date _____

Convulsions/Seizures? _____ Age _____ Type _____

Treatment _____

Allergies? _____

Medication _____

Bee Stings _____

Foods _____

Asthma _____ Treatment _____

Hay Fever _____

Eczema _____