CPU Preschool Child Development History

(To be completed by parent before admission-please circle the correct box)

Child's name______________________________________ DOB___________

1. Do you have any concerns about your child's hearing? Yes No
2. Does your child have ear tubes? Yes No
3. Has your child had trouble with his/her eyes or vision? Yes No
4. Does your child wear glasses? Yes No
5. Does your child take any medications regularly? Yes No
   If yes, name of medication?________________ and for what?_____________
6. Does your child chew unusual things such as pencils, cribs, window ledges, paint chips or hair (PICA)? Yes No
7. Does your child have any trouble sleeping? Yes No
8. Has your child ever been recommended for any other health or educational services ? Yes No

Growth and Development History

1. Did you (mom) receive prenatal care? Yes No
2. Were there any problems during pregnancy? Yes No
3. Was this child premature? Yes No
   If yes, how many weeks early___________ Weight at birth___________
4. Did this child require any special medical care/hospitalization during their 1st month?
   If yes, please explain____
5. Has your child been seen by a medical specialist other than a regular MD? Yes No
6. Is your child able to answer simple questions? Yes No
7. Does your child speak so you can understand him/her? Yes No
8. Does your child speak so other adults can understand? Yes No
9. Does your child seem to speak as well as other children the same age? Yes No
10. If your child does not talk, does he/she make sounds? Yes No
11. If your child does not talk, does he/she make gestures to communicate? Yes No
12. Do you think your child has a speech problem? Yes No
13. Is your child able to follow instructions? Yes No
14. Is your child potty trained for both bladder and bowel? Yes No
15. Can your child dress him/herself? Yes No
16. Does your child get along well with?
    Mom Yes No Siblings Yes No
    Dad Yes No Other Children Yes No
    Other Adults Yes No
    Comments____
    ____
    ____
17. Does your child have any restrictions? Yes No
    If yes, what?____

(over)

18. Are you concerned about your child in any of the following areas?

	Yes	No
Bedwetting	Yes	No
Difficulty going to bed or staying in bed	Yes	No
Bad dreams, wakefulness, disturbed sleep	Yes	No
Nail biting, nervous habits	Yes	No
Thumb sucking/pacifier sucking	Yes	No
Stuttering, stammering	Yes	No
Restlessness, overactive	Yes	No
Day dreaming, mind not on what he/she is doing	Yes	No
Irritable, easily upset, feelings hurt easily	Yes	No
Overly cautious, fearful, shy	Yes	No
Acts without reason, on the spur of the moment	Yes	No
Wants too much attention or comfort, clinging	Yes	No
Breath holding	Yes	No
Stubborn, disobedient, uncooperative	Yes	No
Selfish, unable to share	Yes	No
Anger, temper tantrums	Yes	No
Destroys things on purpose	Yes	No
Clumsiness, awkwardness	Yes	No
Repeats actions or words needlessly	Yes	No
"Rocks" his/her body	Yes	No
Too much concern about sex for their age	Yes	No

Please list any areas of great concern____

____

What do you see as your child's greatest strength's___________________________________

____

I understand that in signing this, I give permission for this information to be shared with school personnel that have a legitimate educational interest in my child.

Parent's signature_____________________________________ Date_________________

5/2011