Home and Background Information

Name of Child:_____ Date of Birth:_____

Does your child have a nickname?_____ If so, what is it?_____

What, if any allergies, does your child have at this time?_____

Please send in your child's Immunization Record and Universal Health Record with this form. It will remain in your child's file in our office. When your child has an appointment for shots, please stop by the office so the records can be updated.

Child's Doctor's Name/Phone #: _____

Did you have a full term, normal pregnancy and delivery?_____

Describe your outdoor play space at home?_____

Does your child have his/her own room?_____ If not, who shares it?_____

Do both parents live with the child?_____ If not, explain briefly?_____

_____

Has your child lived elsewhere than the present home? _____ If so, please explain:_____

_____

What is your child's current daily sleeping schedule? AM Wake up: _____ PM Bedtime: _____

Daily naps?:_____ Does your child sleep through the night?_____

If not, when does your child usually wake up at night?_____

List any fears your child has that you are aware of: _____

How does your child react to strangers?_____

What does your child find soothing or comfortable? _____

Is your child using a cup, bottle or both?_____ Is your child now on baby food or table food?_____

Are you breastfeeding?_____ If yes, at what times?_____

What times does your child receive his/her bottle each day?_____

Are you flexible on your child's feeding times?_____ Currently, how many ounces in each bottle is your child drinking?_____ Is your child taking formula, whole milk, skim milk, or other?_____

Where does your child spend most of his/her awake hours? _____

What toys and activities make him/her happy?_____

When does your child usually have bowel movements?_____

What does your child call his/her bowel movements?_____ and urination?_____

Has your child begun potty training or are they trained?_____

Describe your child's potty routine:_____

_____

List foods your child is now eating:

Vegetables **Fruits** **Meats** **Juices** **Cereals**

	Time	Food	Amount
Breakfast			
AM snack			
Lunch			
PM snack			
Other			
Milk			
Juices			

** Please update schedule as needed

Social Relationships and Experiences:

Does your child have playmates at home?_____ Outside of home:_____ What age are his/her playmates:_____ Does your child have imaginary playmates?_____

If yes, describe:_____

With what does your child play with most outdoors?_____ Indoors?_____

Has your child had any previous playgroup experience?_____ Did they enjoy it?_____

What do you want your child to get out of Hillcrest Academy?_____

_____

Is your child currently under any medical treatment?_____ if yes, explain_____

_____

Please answer the following and include dates where necessary: Contact with TB:_____

Dental checkup:_____ Emotional or Mental Testing:_____

Tonsils and/or Adenoids out:_____ Hearing checked:_____