

**CHILD DEVELOPMENTAL HISTORY**  
**PRESCHOOL, PRE-KINDERGARTEN, AND KINDERGARTEN**

In an effort to better understand your child, we appreciate your answering the following questions as honestly and succinctly as possible. Thank you for your time and cooperation.

*Child's Name:* \_\_\_\_\_ *Nickname:* \_\_\_\_\_

*Gender:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

**Address:** \_\_\_\_\_

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

**Father's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Names/Ages of Siblings:** \_\_\_\_\_ (age)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Language(s) Spoken in home:** \_\_\_\_\_

**Developmental History:**

- Pregnancy \_\_\_\_\_
- Delivery \_\_\_\_\_
- Infancy \_\_\_\_\_

**Milestones:** (approximate ages)

- Sat up unassisted \_\_\_\_\_
- Crawled \_\_\_\_\_
- Walked \_\_\_\_\_
- Talked \_\_\_\_\_
- Toilet Trained \_\_\_\_\_

**Please indicate any Parental Health Issues:**

\_\_\_\_\_

**Please indicate any child's illnesses, allergies or significant injuries:**

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**Briefly Describe:**

- Child's Eating Habits \_\_\_\_\_
- Child's Sleeping Habits \_\_\_\_\_
- Does she/he share a room? \_\_\_\_\_
- How physically active is your child? \_\_\_\_\_
- Does your child enjoy being read to? \_\_\_\_\_
- What kind of activities does your child prefer? \_\_\_\_\_
- Does your child watch TV? \_\_\_\_\_ How often each day? \_\_\_\_\_
- Have there been any significant experiences in your child's life?  
(i.e. moves, illnesses, deaths, separations)  
\_\_\_\_\_

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*Please list your child's previous school/group experiences:*

- Place: \_\_\_\_\_ Age: \_\_\_\_\_ How Long? \_\_\_\_\_
- Place: \_\_\_\_\_ Age: \_\_\_\_\_ How Long? \_\_\_\_\_

*How does your child feel about coming to Saint Joseph Elementary School?*

**Excited** \_\_\_\_ **Apprehensive** \_\_\_\_ **Other** \_\_\_\_

*Has your child received any Special Education Services?* \_\_\_\_\_ (yes) \_\_\_\_\_ (no)

*Has your child had any previous physical, psychological or education evaluation?*

If so, please describe and attach documentation.

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*Is your child taking any medication(s)? If your child is taking a medication, please list the name of the medication and how often.*

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*What else would you like us to know about your child to help ensure that he/she may have a positive school experience?*

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*Name of child's pediatrician:* \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_