

GENERAL MEDICAL (CONTINUED)

Does your child have allergies?	Yes	No
If yes, describe: _____		
Is your child presently on any medications?	Yes	No
If yes, please describe: _____		
Please describe any other health concerns: _____		

CHILD'S DEVELOPMENT

Can your child-

feed him or herself using a spoon and/or fork?	Yes	No
wash and dry his or her own hands?	Yes	No
help with dressing or dress with little assistance?	Yes	No
stay with a babysitter?	Yes	No
speak so that he or she can be understood by others?	Yes	No
express his or her thoughts and needs easily?	Yes	No

Do you have any concerns about your child's appetite or willingness to try different foods? Yes No

If yes, explain: _____

Do you have any concerns about your child's sleeping patterns? Yes No

Is going to bed at night difficult? Yes No

Does your child require a nap? Yes No

Is your child-

Highly active?	Yes	No
Very quiet?	Yes	No
Toilet trained? At what age? _____	Yes	No
In need of help with toileting?	Yes	No

Does your child-

Play with blocks or other construction toys without help?	Yes	No
Use crayons to scribble draw?	Yes	No
Listen to stories being read to him or her?	Yes	No
Turn pages of a book and look at pictures?	Yes	No
Recall stories or events?	Yes	No
Enjoy playing alone or with imaginary friends?	Yes	No
Talk with your friends/relatives who come to visit?	Yes	No
Follow simple, age-appropriate directions?	Yes	No
Have difficulty with separation?	Yes	No

What are your child's favorite activities? _____

Does your child have opportunities to play with other children?	Yes	No
---	-----	----

How many hours a day does your child spend watching TV/Computer? _____

Does he or she sit very close to the TV/Monitor?	Yes	No
Does he or she turn up the volume very high?	Yes	No

Are there any other things you would like to tell us about your child?
