

Northwood Academy Developmental Inventory Pre-school, K4 and K5

Student's Name _____ Age / Entering Grade _____

Who is completing inventory? Mother Father Guardian Other _____

FAMILY INFORMATION

Student Family Info: Traditional Blended Single Parent Other _____

With whom has the child lived for most of the past year? _____

Other children in the family - how many older? _____ How many younger? _____

Any other people living in the household? _____

PRE-SCHOOL/CHILD CARE HISTORY

Has your child attended pre-school/child care before? Yes No

If yes, at what age(s) and for how long? _____

MEDICAL HISTORY

Where there any significant problems during pregnancy? Yes No

If yes, explain: _____

Was your child more than 3 weeks premature? Yes No

If yes, how many weeks premature? _____

Did your child stay in the hospital longer than the mother? Yes No

If yes, explain: _____

EYES

Has your child ever had trouble seeing? Yes No

Does your child hold books and objects close to his or her face? Yes No

Does your child wear glasses to help vision? Yes No

Has your child had any other vision problems? Yes No

If yes, explain: _____

EARS

Has your child had frequent ear infections? Yes No

Has your child ever had trouble hearing? Yes No

If yes, explain: _____

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding Yes No

on to things? If yes, explain: _____

GENERAL MEDICAL

Has your child ever had any significant injuries or hospitalizations? Yes No

If yes, explain: _____

Does your child have allergies? Yes No

If yes, please list: _____

GENERAL MEDICAL (continued)

Is your child presently on any medications? Yes No
If yes, please list: _____
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 is 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? If yes, explain: Yes No

What time does your child go to bed at night? _____ Normally easy? With difficulty?
What time does your child arise in the morning? _____ Normally easy? With difficulty?
Does your child sleep through the night? Yes No

Does your child benefit from / need a nap or rest time after lunch? Yes No
Please describe your child's current nap / rest pattern: _____

Is your child - Very active? Yes No
Very quiet? Yes No
Toilet (bowel) trained? At what age? _____ Yes No
In need of help with toileting? Yes No

Does your child - Use crayons to scribble / draw? Yes No
Play with blocks or other construction toys? 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 / movies? _____
Does your child play computer / video games? Yes No
If yes, please describe: _____
Are there any other things you would like to tell us about your child?

