Getting to Know Your Toddler…

Name: _____ D.O.B. _____

Meal Time

Does your child have any known allergies? **YES** **NO** Known allergies _____
I will provide food for my child everyday **YES** **NO**
I will use the food provided by Growing Generations **YES** **NO**

Self-feeding skills (check all that apply):
____ just beginning ___ uses only fingers ___ uses spoon w/difficulty ___ uses spoon well

___ uses "sippy" cup ___ uses cup/glass

Information we should know about meal time at home: _____

Please list any table food your child CAN NOT have or if your child has any dietary restrictions:
_____

Special Instructions for feedings:
_____

What type of communication do you prefer (please circle): **Email** **phone call** **talk in person**

How does your child like to be comforted: _____

What fears does your child have? _____

Does your child have a particular comfort toy?_____

Additional information we should know about your child?_____

Developmental History:

Has your child been away from you before? _____ Yes _____ No How Frequently? _____
Has your child been in group before? _____ Yes _____ No If yes, explain _____
How does your child handle separation from parent? _____ without upset _____ Briefly/mildly upset
Is your child easily frightened? ? _____ Yes _____ No If yes, explain _____
How do you comfort your child? _____
Emotional Behavior (please indicate all that apply):
__ Happy __ Calm __ Active __ Cheerful __ Stubborn __ Cooperative

__ Quiet __ Independent __ Crying

What are child's favorite toys and activities? _____

Sleep Patterns:
Describe any special ways of helping your child go to sleep? _____

_____

Does your baby cry when going to sleep? ____ Yes ___ No If yes, for how long? _____
What is your baby's present sleep patter?

Night:	from _____ to _____	from _____ to _____
AM Nap:	from _____ to _____	from _____ to _____
PM Nap:	from _____ to _____	from _____ to _____

Other sleep information: _____

Toileting Patterns:
Does your child indicate discomfort when wet or soiled? ___ yes ___ no
Has your child shown interest in sitting on the toilet? ___ yes ___ no
Are you currently working on toilet training with your child? ___ yes ___ no
If yes, how long? _____
When awake, child wears: ____ diapers ____ regular underpants
During sleep, child wears: ____ diapers ____ regular underpants
My child uses this brand of Diapers: _____ Size: _____
My child uses this diaper ointment: _____
How does your child indicate the need to go? ____ does not indicate _____ goes on own
_____ needs an adult to take them to the toilet: how often? _____
_____ tells adult of need to use the toilet: with what words? _____
Are you using any reinforcements/incentives/rewards for using the toilet? ____ yes _____ no
If yes, explain: _____
Have you tried training before and discontinued? ___ yes ___ no
If yes, explain: _____
Other toileting information: _____

Parent Signature: _____ **Date**: _____

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CHILD DEVELOPMENT CENTER