All About Me

Child's Name ___________________________________ Age ___________ Today's Date ____________

Please tell me about your family's cultural values/important holidays/traditions:

____

____

____

____

____

Please tell me what your child is afraid of:

____

____

Please list their favorite toys, games, and activities:

____

____

____

____

____

Please list their favorite movies or cartoons:

____

____

____

What are your child's favorite art activities?

____

____

____

Is your child a picky eater? If yes, how do you handle this at meal times?

____

____

What are your child's favorite foods?

____

____

Is your child right handed? Left-handed? Unsure yet? *(circle one)*

Does your child prefer to play alone or in a group? ____

Do they have any special needs (Speech, ADD, ADHD, Diabetes, Epilepsy, Allergies, Autism, etc.)?

____

____

____

____

Is there anything specific I need to know about their special need in order to best help your child?
____
____
____

Do you have any other concerns about your child's development: Emotionally? Socially? Physically? Intellectually? Hearing? Sight? Special Needs? Please explain your concerns: ___________________________
____
____
____
____

Please tell me about your toilet learning approach:
____
____
____
____
[I will work with you in order to keep the process free of punishment or power struggles]

What is your child's home language? ____

Please list any siblings they have and their ages:
____
____

Does your child have any pets? ____

Please describe their previous child care experiences (if any):
____
____
____
____
____

Describe your family mealtime setting at home. For example: Does your entire family sit down at the table and eat together?
____
____
____
[This answer will help me understand any positive or negative reaction your child shows toward our routine]

Please tell me if you have any specific requests or if there is anything you would like your child to learn while in my care:
____
____
____
____
____
____
____

Health History

You are not required to answer the following questions. However, any information you do provide will help in case of an emergency trip to the hospital.

Does your child have a problem with any of the following?	YES	NO	*Has your child had any of the following diseases?*	YES	NO
Constipation			Asthma		
Convulsions			Bronchitis		
Diarrhea			Chicken Pox		
Fainting Spells			Diabetes		
Frequent Colds			Heart Disease		
Frequent Ear Infections			Hepatitis		
Frequent Sore Throat			Impetigo		
Lice			Measles		
Ring Worm			Mumps		
Skin Rash			German Measles		
Soiling			Polio		
Upset Stomach			Scarlet Fever		
Urinary Problems			Tuberculosis		
Worms			Whooping Cough		

Last Physical Examination ____

1. Other illnesses? (*besides above*)
   ____
   ____

2. Has your child been hospitalized? (*explain*)
   ____
   ____

3. Has your child had injuries with fractures or loss of consciousness? (*explain*)
   ____
   ____

4. Last vision test date: ___________________ Last hearing test date: __________________ *(if known)*

5. Last dentist visit date: ____

6. Any other members of your family history of: ASTHMA _____ DIABETES _____ EPILEPSY_____